

ABSTRACT

SCHOOL OF SOCIAL WORK

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M.S.W. UNIVERSITY OF SOUTH CAROLINA, 1990

THE ROLE OF RELIGIOUS/SPIRITUAL COPING AMONG AFRICAN-AMERICAN INFORMAL CAREGIVERS OF OLDER ADULTS

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Dissertation dated December 2007

This study examined the relationship of sociodemographic background, religious/spiritual coping, overall health, and perceived stress among a sample of African-American informal caregivers of physically and emotionally dependent community dwelling older adults. Quantitative data used in this study was provided by participants selected from the first wave of the longitudinal Family Relationships in Late Life Two (FRILL2) Study; The Family Relationship in Late Life (FRILL, R01AG15321) project is funded by the National Institute of Health/National Institute on Aging. The findings reported in this study included 173 African-American caregivers from a total number of respondents (N = 417) who participated in the FRILL2 Study. The majority of the participants of this study were married (52%) females (70%) providing care to co-residing older adults sixty-five years of age or older (87%) who lived in various communities. The results of the study indicated a strong relationship between the utilization of religious/spiritual coping and perceived stress among African American

informal caregivers of physically and emotionally dependent community dwelling older adults.

THE ROLE OF RELIGIOUS/SPIRITUAL COPING
AMONG AFRICAN-AMERICAN INFORMAL CAREGIVERS
OF OLDER ADULTS

A DISSERTATION
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF DOCTOR OF PHILOSOPHY

BY

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ATLANTA, GEORGIA

December 2007

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ACKNOWLEDGEMENTS

First, I would like to give thanks to almighty God for blessing me with the strength and endurance to complete this project. I acknowledge my parents, Edward Samuel, Sr. and the late Lue Alice Samuel, for instilling in me the will and drive to pursue my hopes and dreams and for giving me so much love and wonderful life experiences. I also acknowledge my sisters, brothers, extended family, and friends for their undying support and words of encouragement, especially Darlene who provided me with direct support, tough love, encouragement, and much prayer. I give special thanks to Dr. Donald McLellan who stated, "You can be a 45 year old woman without a Ph.D. or a 45 year old woman with a Ph.D." Thanks for motivating me to be the latter.

Furthermore, I gracefully acknowledge those who provided constant prayer, love, kindness, and verbal words of encouragement and support: Bishop R. Davis and the Greater Highway Church of Christ, especially my church family in Latta, South Carolina, and Pastor William Bland and the Grace Fellowship Church Family in Georgia.

I would like to thank my committee, Dr. Margaret Counts-Spriggs (Chair), Dr. Richard Lyle, and Dr. Robert Waymer for all the support, scholarly guidance, time, and direction provided throughout this process. Special thanks to Dr. Brenda Hayes for her support and guidance as well. Finally, a heartfelt thank you goes to Dr. Gail Williamson and the FRILL2 Research Team for all of the support, guidance, expertise, and words of encouragement. Also, special thanks are given to Mrs. King and Mrs. Gray-Goul.

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CHAPTER I

INTRODUCTION

The world population is aging rapidly. Both the number and proportion of people aged 65 years and older is increasing. Individuals who are age 65 and older currently make up about thirteen percent of the United States population. The U.S. Census Bureau (2004) predicts that in 25 years twenty percent of the U.S. population will be comprised of individuals 65 years of age or older. According to Waite (2004), as our population continues to age over the next 50 years the United States will undergo a profound transformation in which one citizen in five will be 65 years of age or older. What effect will this increase have on health care delivery systems or any other programs that provide services to the elderly?

Researchers, society and older people view aging differently. However, the phenomenon of aging and the identity of older adults are defined by chronological criteria and individual differences in terms of functional age (Hooyman & Kiyak, 2005). The significant differences among the older population are displayed within the following subgroups: the “young old” (ages 65-74), the “old-old” (ages 75-84), and the “oldest old” (ages 85 and over) (Riley & Riley, 1986).

Waite (2004) reported that the life expectancy of Americans has increased. Therefore, the oldest old population itself will age, presenting large increases of the number of people who are 85 years of age and older. According to the 2004 U.S. Census Bureau, the oldest old Americans account for just over one percent of the population, but

they exert a disproportionate effect on both their families and the health care system. The oldest old are more likely than the young old to live in nursing homes, to have substantial disabilities and to have restricted financial resources. Moreover, if the Census Bureau is correct, by 2050 one American in 20 will be 85 years old or older, compared to one in 100 today.

Older adults are living longer than their predecessors. Individuals between the ages 65 and 74 are living healthier and longer due to pain relieving medication, radical medical treatment and surgery, diet, and exercise (President's Council on Bioethics, 2005). Various studies report that most older adults are relatively healthy but the oldest old suffer from more chronic and debilitating illnesses, are more frail, and have fewer financial resources and social support than the youngest old (Bowling, Seetai, Morris & Ebrahim, 2007; Stenberg, 2005; Cole, 2004; Joint Economic Committee Congress of the United States, 2004; Jitapunkul, et al., 2003). Chronic illness and functional disability, rather than acute illness, are both major factors in the health and quality of life among older adults. Therefore, it is not surprising that the percentages of disability and difficulty with performing activities of daily living increase as the elderly grow older (National Association of Social Workers (NASW), 2003).

Long term care (LTC) is a system of providing social, personal, and health care services over a sustained period to people who in some way suffer from functional impairment, including a limited ability to perform basic self and family care responsibilities necessary for independent living known as activities of daily living (ADL). Such activities include meal preparation, bathing, dressing, shopping, cleaning,

and handling financial matters, light home maintenance, and household chores. Within the LTC system, many caregivers, whether professional or informal, provide for the physical, emotional, and social needs of another person, who often is physically and/or emotionally dependent and cannot provide for his or her own needs (Barker, 2003).

Caregiving is the act of assisting other people with personal care, household chores, transportation, and other tasks associated with daily living; provided by either family members without compensation or by licensed and/or trained professionals (Hooyman & Kiyak, 2005). Informal caregivers are family, friends, and neighbors who provide unpaid assistance for persons requiring help with ADL (Hooyman & Kiyak, 2005). In contrast, formal caregivers are skilled or trained direct care workers who are paid to provide hands-on care in both private homes and institutional settings (Hooyman & Kiyak, 2005). For the purpose of this study, family/informal caregiver was defined as an individual who provides unpaid care and/or support to older adults who live in the community and have at least one limitation with their activities of living (Administration on Aging, 2003). Therefore, throughout this document the term informal caregivers refer to family caregivers.

Statement of the Problem

According to the Administration on Aging (2006), more than 22.4 million families which include spouses, adult children, other relatives and friends provide long-term care for community dwelling older adults. A family/informal caregiver is defined as an individual who provides care and/or support to older adults who live in the community and have at least one limitation with their activities of living (Administration on Aging

(2003). In contrast, formal caregivers are skilled or trained direct care workers who are paid to provide hands-on care in both private homes and institutional settings (Hooyman & Kiyak, 2005). In a 1997 National Survey measuring the economic value of informal caregiving in the United States, it was estimated that the value of unpaid caregiving in 2000 would be \$257 billion supports the significance of family caregiving (Gould, 2004). Families, not social service agencies, nursing homes, or government programs, are the mainstay underpinning long-term care for older persons in the United States.

Gerontologists are concerned about the unpaid costs incurred as well as the negative consequences related to burn out, stress and other losses often experienced by informal caregivers. These concerns are conceptualized as objective and subjective burden. Objective burden can be defined as the daily demands of caregiving, (such as the older relative's symptomatic behaviors), changing family roles, unmet personal health problems, and other disruptions of family life. Whereas, subjective burden includes the feelings and emotions aroused in family caregivers, such as grief, anger, guilt, worry, sadness, depression, sleeplessness, withdrawal, and empathetic suffering (Hooyman & Kiyak, 2005).

Caregiver research has increased understanding about the impact of chronic illness in families and it has explored the complex relationships between stress and human responses (psychological and physiological) in the context of aging, identifying caregiving as a chronic stressor (Vitaliano, Young, & Zhang, 2004). According to Leblanc (2004) and his colleagues, care-related stress can have deleterious effects on the health of informal caregivers. In contrast, the use of religiosity/spirituality is most likely

to have a positive impact on caregivers' health. Religiosity (Religion) is defined as an organized system of beliefs, practices, and rituals designed to incorporate an intimate relationship with God; however, spirituality is often referred to as a personal quest for understanding answers to ultimate questions about life, meaning, and relationships to the sacred (Koenig, McCullough, & Larson, 2001).

Some examples of religiosity/spirituality include: daily spiritual experiences, meaning, values, beliefs, forgiveness, private religious practices, religious/spiritual coping, religious support, religious/spiritual history, commitment, organizational religiousness, and religious preference (Leblanc, Driscoll, & Pearlin, 2004). Caregivers who used religion or spiritual beliefs to cope with the stress of caregiving were more likely to have a good quality of relationship with the care recipient and a good quality relationship was associated with less depression among caregivers (Chang, Noonan, & Tennstedt, 1998).

In sum, chronic illness and functional disability, rather than acute illnesses, are both factors linked to the quality of life among the elderly. The increase of disability and difficulty performing activities of daily living among older adults also increases the need for caregiving.

Purpose of the Study

The purpose of this study was to explore the role of religious/spiritual coping among African-American informal caregivers of older adults. The study defined informal caregivers as individuals who receive no financial compensation to provide for the physical, emotional, and/or social needs of another individual aged 55 and older. The

caregivers in this study had to co-reside with the older adult; however, they did not have to be related to the care recipient in order to participate in the study. The primary focus of this research was to examine the relationship of socio-demographic background, religious/spiritual coping, overall health, and perceived stress among co-residing African-American informal caregivers of physically and/or emotionally dependent community dwelling older adults.

Research Questions

The research questions of this study were as follows:

1. Is there a relationship between the utilization of religious/spiritual coping and gender among African American informal caregivers of physically and emotionally dependent community dwelling older adults?
2. Is there a relationship between the utilization of religious/spiritual coping and income among African American informal caregivers of physically and emotionally dependent community dwelling older adults?
3. Is there a relationship between the utilization of religious/spiritual coping and education among African American informal caregivers of physically and emotionally dependent community dwelling older adults?
4. Is there a relationship between the utilization of religious/spiritual coping and residency among African American informal caregivers of physically and emotionally dependent community dwelling older adults?

5. Is there a relationship between utilization of religious/spiritual coping and overall health among African American informal caregivers of physically and emotionally dependent community dwelling older adults?
6. Is there a relationship between utilization of religious/spiritual coping and less perceived stress among African American informal caregivers of physically and emotionally dependent community dwelling older adults?

Hypotheses

The null hypotheses for the study were as follows:

1. There is no statistically significant relationship between the utilization of religious/spiritual coping and gender among African American informal caregivers of physically and emotionally dependent community dwelling older adults?
2. There is no statistically significant relationship between the utilization of religious/spiritual coping and income among African American informal caregivers of physically and emotionally dependent community dwelling older adults?
3. There is no statistically significant relationship between the utilization of religious/spiritual coping and education among African American informal caregivers of physically and emotionally dependent community dwelling older adults?
4. There is no statistically significant relationship between the utilization of religious/spiritual coping and residency among African American informal caregivers of physically and emotionally dependent community dwelling older adults?

5. There is no statistically significant relationship between utilization of religious/spiritual coping and overall health among African American informal caregivers of physically and emotionally dependent community dwelling older adults.
6. There is no statistically significant relationship between utilization of religious/spiritual coping and perceived stress among African American informal caregivers of physically and emotionally dependent community dwelling older adults.

The following dependent and independent variables were examined while exploring the role of religious/spiritual coping among African-American informal caregivers of older adults:

1. Dependent Variable – religious/spiritual coping among African-American informal caregivers.
2. Independent Variables – perceived stress and overall health.

For the purpose of this study perceived stress was defined as an individual's perception that life is unpredictable, uncontrollable, and overloading (Cohen, Karmack, & Mermelstein, 1983). According to the *World Health Organization (WHO)*, health is the state of complete physical, mental, and social well being, not merely the absence of disease or infirmity (Barker, 2003). This definition was used to assess perceived overall health. The dependent variable religious/spiritual coping was defined as religious/spiritual methods of coping that affect the psychological, social, physical, and spiritual adjustment of people to crises, for better or worse (Pargament, Smith, Koenig, & Perez, 1998).

Significance of the Study

Recent studies have shown how religion and spirituality influence physical and mental health. Koenig (1997) reviewed over ten research studies from 1988 to 1995 and found that religiosity has a positive effect on health. In this study, Koenig found that four out of ten patients admitted to a tertiary-care teaching hospital believed religion was the most important factor that helped them to cope. Studies examining the relationship between religion and health have become increasingly of interest to social, behavioral, and health researchers (Chatters, 2000). Shah, Snow, and Kunik (2001) investigated the prevalence of religiously based coping mechanisms used by Alzheimer's caregivers and found a high utilization of spiritual and religious coping mechanisms amongst these caregivers.

There has been a paucity of research that examined the relationship of religious/spiritual coping, perceived stress, and overall health among informal caregivers. An extensive review of literature was conducted to find research that examined the relationship of religious/spiritual coping, perceived stress, and overall health among co-residing informal caregivers; however, no studies were found that examine these variables and identified their participants as caregivers who co-resided with their elderly care recipients. Additionally, no studies were found that examined these variables and identified the subjects as African-American caregivers who co-resided with their elderly care recipient. In sum, this study examined the relationship of religious/spiritual coping, perceived stress, and overall health among co-residing African-American informal caregivers of physically and/or emotionally dependent community dwelling older adults.

According to the National Alliance for Caregiving (2004), more than one in three (35%) African-Americans say they spend one to eight hours per week providing care and more than eight in ten (84 %) say they cope with caregiving stress by praying.

African-American caregivers are more likely to provide higher levels of care, to have higher levels of self-efficacy and gains in relations to caregiving, and to be more economically disadvantaged than their white counterparts (Hooyman & Kiyak, 2005).

Researchers have reported that African-Americans' use of religious coping strategies may account for differences in overall appraisals of their experience (Connell & Gibson, 1997). Taylor, Chatters & Levin's (2004) review of literature suggests that religious beliefs and coping strategies are relevant for understanding several aspects of the African-American caregiving experience, including primary appraisal processes.

Research supports the relationship between religiosity/spirituality and better health (Moberg, 2005; Armstrong & Crowther, 2002; Chatters, 2000; Koenig, 1997).

Religiosity (religion) is an organized system of beliefs, practices, and rituals designed to incorporate an intimate relationship with God. In contrast, spirituality is a personal quest for understanding answers to ultimate questions about life, meaning, and relationships to the sacred (Koenig, McCullough, & Larson, 2001). However, religious/spiritual coping are religious and/or spiritual methods of coping that affect the psychological, social, physical, and spiritual adjustment of people to crises, for better or worse (Pargament, Smith, Koenig, & Perez, 1998).

A study that yields positive association between the greater use of religious/spiritual coping and less perceived stress among African-American informal

caregivers will enhance the lives of physically and emotionally dependent older adults and their caregivers. This research supports the value of incorporating religious/spiritual aspects in social work programs and interventions. It also encourages the need for future research that will support the implementation of policy that establishes social services that utilizes religious/spiritual based interventions.

It is extremely important for social workers, health care professionals and investigators to thoroughly review and research prevention and intervention programs in order to help increase the quality of care for all patients, especially African-American elders and their families. The amount of knowledge, perception of health information presented, and an individual's spiritual/religious beliefs will have an impact on his/her response to stressful life events. Research that includes religious/spiritual coping among informal caregivers will have important implications for community services and policy development. The results may be relevant to practitioners who work directly with African-American disabled elders and their informal caregivers. Such results could strengthen psychological interventions that help caregivers use their religious belief system to cope with their caregiving experience. These findings may also help facilitate caregiver interventions that increase collaborations among social workers, religious leaders, and community organizations.

Definition of Terms

Religion (Religiosity) – An organized system of beliefs, practices, and rituals designed to incorporate an intimate relationship with God (Koenig, McCullough, & Larson, 2001).

Spirituality – A personal quest for understanding answers to ultimate questions about life, meaning, and relationships to the sacred (Koenig, McCullough, & Larson, 2001).

Religious/Spiritual Coping – Religious/spiritual methods of coping that affect the psychological, social, physical, and spiritual adjustment of people to crises, for better or worse. Positive religious/spiritual coping reflects benevolent religious involvement in the search for significance, whereas, negative religious/spiritual coping reflects religious struggle in coping (Pargament, Smith, Koenig, & Perez, 1998).

Coping Styles (methods) – Various selected ways/techniques used by an individual to solve problems, remove or eliminate stressors or to reduce the intensity of a stressful life event (Taylor, 1999).

Perceived Stress – An individual's perception that their life is unpredictable, uncontrollable, and overloading (Cohen, Kamarck, & Mermelstein, 1983).

Health – The state of complete physical, mental, and social well being, according to the *World Health Organization (WHO)*, not merely the absence of disease or infirmity (Barker, 2003).

Caregiving – The act of assisting other people with personal care, household chores, transportation, and other tasks associated with daily living; provided by either family members without compensation or by licensed and/or trained professionals (Hooyman & Kiyak, 2005).

Caregiver – A person who provides for the physical, emotional, and social needs of another person, who often is dependent and cannot provide for his or her own needs (Barker, 2003).

Family/Informal Caregivers – Family, friends, and neighbors who provide unpaid assistance for persons requiring help with ADL (Hooyman & Kiyak, 2005).

Family/Informal Caregiving – The act of assisting people with personal care, household chores, transportation, and other task associated with daily living without receiving financial compensation (Hooyman & Kiyak, 2005).

Formal Caregivers – Direct care workers such as nurse aides, personal assistants and home care workers who are paid to provide hands-on care in both private home and institutional settings (Hooyman & Kiyak, 2005).

In summary, the study was divided into five interrelated chapters. Chapter I introduces the study and includes the statement of the problem, the purpose of the study, the research questions, the hypotheses, the significance of the study and the definition of terms. Chapter II provides the review of relevant literature and includes the theoretical framework. Chapter III describes the methodology, research design, study site, the sample, the instrumentation, treatment of the data, and limitations of the study. Chapter IV provides an analysis of the data and presents the findings. Chapter V includes the summary, conclusions, and implications of the findings.

CHAPTER II

REVIEW OF LITERATURE

The purpose of presenting this review of literature is to lay a scholarly foundation in order to establish a need for the study. This chapter is a review of current literature on religious/spiritually coping and the impact of stress as it relates to the overall health of African-American informal caregivers of community dwelling older adults. This review covers a historical perspective of caregiving, family caregiving, African-American caregivers, African-American elderly, religiosity and spirituality, coping, stress and caregiving, and health related issues. Religious/spiritual coping measurements, perceived stress, and overall health of informal caregivers are reviewed in order to establish an understanding for the data analysis from responses of African-American co-residing informal caregivers who provide emotional and physical care to community dwelling older adults.

There has been a paucity of research that examined the relationship of religious/spiritual coping, perceived stress, and overall health among informal caregivers. An extensive review of literature was conducted to find research that examined the relationship of religious/spiritual coping, perceived stress, and overall health among co-residing informal caregivers, however, no studies were found that examine these variables and identified their participants as caregivers who co-resided with their elderly care recipients. Additionally, no studies were found that examined these variables and

identified the subjects as African-American caregivers who co-resided with their elderly care recipient.

Who are Caregivers?

In general, a caregiver is one who provides for the physical, emotional, and social needs of another person, who often is dependent and cannot provide for his or her own needs (Barker, 2003). The American Association of Retired Persons (2005) defines caregivers as unpaid family or unrelated individuals who provide health and personal care to individuals in the home. Hooyman and Kiyak (2005) defines family caregiving as the act of assisting people with personal care, household chores, transportation, and other tasks associated with daily living. This act is provided by family members or friends without compensation.

According to the Administration on Aging (2005), families, not social services agencies, nursing homes, or government programs, are the mainstays underpinning long-term care (LTC) for other persons in the United States. These caregivers include spouses, adult children, and other relatives and friends.

The Administration on Aging (2005) also reports that the degree of caregiver involvement has remained consistent, bearing witness to the remarkable resilience of the American family in taking care of its older population. This is despite increased geographic separation, greater numbers of women in the workforce, and other changes in family life. Thus, family caregiving has been very positive in many aspects. It has been a budget-saver to governments faced annually with the challenge of covering the health and

long-term care expenses of citizens who are ill, not working, and with chronic disabilities.

Family Caregiving

Family care is the most important source of assistance for people with chronic or disabling conditions who require long-term care (LTC). Although policymakers and health care providers frequently associate LTC with nursing homes, that perception discredits the reality of where most LTC is provided and by whom (Family Caregiver Alliance, 2006). Family members, not social service agencies, nursing homes, or government programs, are the main long-term care providers for older persons in the United States (Administration on Aging, 2005). Nearly 10 million Americans need long-term care in the United States. Among adults who need long-term care services and supports, most (80 percent) live at home or in community settings, not in nursing homes (Family Caregiver Alliance, 2006).

Home health care (domiciliary care) can be provided in the patient's home by healthcare professionals (formal/skilled caregivers) or by family and friends (informal family/primary caregivers). However, the term, home care, is often used to define non-medical care or custodial care, which is care that is provided by persons who are not nurses, doctors, or other licensed medical personnel; whereas, the term, home health care, refers to care that is provided by licensed medical personnel (Wikipedia, 2006).

The Family Caregiver Alliance (2006) reported that 78% of adults (age 18+) who receive LTC at home get all their care exclusively from unpaid family members and friends, mostly wives and adult daughters. Another 14 percent receive some combination

of family care and paid assistance; only eight percent rely on formal home healthcare alone. The use of formal care (paid care) has declined among community-dwelling older adults (age 65+) with disabilities, while sole reliance on family caregivers has increased.

An estimated 44 million adults (age 18+) provide unpaid assistance and support to older adults and older adults with disabilities who live in the community. In 2000, informal (unpaid) caregiving by family and friends had an estimated national economic value of \$257 billion annually, greatly exceeding the combined costs of nursing home care (\$92 billion) and home health care (\$32 billion). Without family and other informal caregivers, government spending for LTC services would be much higher than it is now (Family Caregiver Alliance, 2006).

The Family Caregiver Alliance (2006) also reported that caregiving has been and will continue to be central to American family life. Family care for people with chronic or disabling conditions is at a tipping point. "Several converging factors make family caregiving a public health issue of critical national significance today" (Family Caregiver Alliance, p. 7):

- Medical advances, shorter hospital stays, limited discharge planning, and expansion of home care technology have transferred the cost and responsibility for the care of frail elders and persons with disabilities onto families. Family members are now asked to assume a health management role in the home and carry out medical tasks that traditionally were carried out by health care providers (e.g., bandaging and caring for wounds, operating pumps and machines at the bedside, administering multiple medications), with little or no preparation, training or support.
- The dramatic demographic shift to an aging population is promoting policymakers to closely examine the financing and service delivery of our health and LTC systems.
- Changes in family life (e.g., more women in the workplace) impact the care recipient and caregiver. Today's family caregivers juggle work, caregiving and other family responsibilities.

- The policy direction to shift from institutional toward more home and community care (what most Americans value and want) depends greatly on family caregiving. Adults with disabilities need a range of services and supports, most of which are provided by family caregivers (Family Caregiver Alliance, p.7-8).

A large body of research over the past 25 years shows family caregivers to be vulnerable and at-risk population that the health and long-term care systems neglects.

The following emphasizes the significant need to address the limited services provided to family (informal) caregivers (Family Caregiver Alliance, 2006):

- Family caregivers receive little support and assistance themselves, despite psychologically stressful and physically exhausting tasks.
- Family caregivers face health risks and serious illness (e.g., heart disease, hypertension, poorer immune function, and lower perceived health status), emotion strain and mental health problems (especially depression).
- Evidence suggests that some caregivers are at risk of mortality
- Family caregivers face workplace issues, financial insecurity and financial burdens.
- Out-of-pocket medical expenses for a family caring for someone who needs help with everyday activities (e.g., bathing, dressing) are more than 2.5 times greater than for a non-caregiving family, 11.2% of income vs. 4.1% (Family Caregiver Alliance, p. 8).

According to Hooyman and Kiyak (2005), the vast majority of family caregivers assist older relatives (residential) daily, with over 80 percent providing care from 1 to 5 hours per day. The type and extent of family care is largely determined by the older adult's functional status, intensity of needed care, co-residence, and the caregiver's gender. The primary forms of care provided by family caregivers are: emotional support; instrumental activities inside and outside the home (e.g., transportation, meal preparation, shopping); personal care (e.g., bathing, feeding, and dressing); and mediating with agencies for services.

The role of family caregiving has been extended throughout the life span (Parks & Pilisuk, 1991). However, providing care to older adults can involve ethical issues for the caregiver such as individual autonomy, death and dying, allocation of resources, and the obligation of family members to provide care (Pratt, Schmall, & Wright, 1987).

According to Briggs (1998), many services provided to physically and/or emotionally dependent older adults may include fulfilling a full range of physical, psychological, and social needs. Cicirelli (1981) provided the following as a comprehensive list of needs of older adults:

1. Homemaking (e. g. meals, shopping, cleaning)
2. Maintenance (of house and yard)
3. Income (for food and other living expenses)
4. Home Health Care
5. Transportation
6. Social and Recreational Activities
7. Psychological Support
8. Spiritual
9. Bureaucratic Mediation (dealing with business and government agencies)
10. Reading
11. Enrichment (special interest)
12. Protection

Informal caregivers are primarily adult children (42%), followed by partners or spouses (25%). However, given rates of widowhood among older adults, along with the sharing of care responsibilities by multiple siblings, children outnumber spouses as active caregivers. Regardless of the type of care relationship, women form over 70% of family caregivers. Although gender roles are changing in our society, women are still the primary nurturers, kin keepers, and caregivers of family members. In fact, 50% of all women provide elder care at some point in the life course, whether as partners, daughters, or daughters-in-law (Hooyman & Kiyak, 2005).

Caregiving

One hundred years ago older people lived in private households and were listed as the head of household. This is still the case today, with most elders living with spouses and only a minority listed as dependents of others. Over 90% of older adults live in a private residence, most with their immediate family. However, living among extended families is not uncommon today. During the last ten years, the number of three-generation households increased with 50 % headed by immigrants and 40 % including individuals with some disability (Armstrong & Kits, 2004).

Informal (unpaid) caregivers provide most of the long term care to community-dwelling disabled older adults. The interest of social research studies of informal caregivers increased during the 1970's and 1980's (Gould, 2004). According to Hooyman and Kiyak (2005), initial caregiving studies focused on U. S. born Caucasian Americans. Little was known about care in ethnic minority communities or other cultures. However, when race was considered, researchers usually compare

African Americans to Caucasians. These comparative studies yield results that African-American caregivers were more likely to provide higher (care recipient requiring more physical assistance) levels of care, to assist extended family members, to have higher levels of expectations to accomplish caregiving tasks, and to be more economically disadvantaged than their Caucasian counterparts. Hooyman and Kiyak (2005) also reported that African-American caregivers were more likely to face more severe care situations and were less likely to use formal supports.

The National Alliance for Caregiving (NAC) and American Association for Retired Persons (AARP) Study (1997) included Caucasians, African-American, Hispanics, and Asians. The results reported higher incidence of caregiving among Asian-Americans (31.7%), African-Americans (29.4%) and Hispanics (26.8%) households than Caucasians (12.1%) households. The larger extended families of African-American are thought to increase the informal care resources of older adults. They are also more likely than white caregivers to live with the care recipient (Tennstedt, 1999).

Dilworth-Anderson, Williams & Gibson (2002) conducted a review of 59 articles published between 1980 and 2000, with focus on race, ethnicity, and/or culture in caregiving. Results suggested that minority caregivers have a more diverse group of extended helpers than do non-Hispanic Caucasians. Female African-American caregivers were more likely to include God as part of their informal support system. Overall, African-American caregivers ranked God or religion as their first source of informal support followed by family, friends, and neighbors. They used formal healthcare systems

as their last resort. African-American caregivers had more persons in their networks than their non-caregiving counterparts. However, they were more likely than Caucasian caregivers to be the sole provider of care. In reference to social networks, African-American informal networks consist of both family and friends. Even though both African-American and Caucasian caregivers reported similar amounts of informal support, white caregivers tended to be more dissatisfied with their overall support. African-American caregivers reported lower levels of caregiver burden but expressed a greater need for formal support services than their Caucasian cohorts.

Research studies that examined stress among African-American caregivers report that they experience less caregiver role strain and less caregiver burden as compared to their Caucasian counterparts. Past literature reported lower levels of depression and emotional distress among African-American caregivers who provide care to elders who suffer from dementia (Knight, et al, 2002). African-American caregivers are better adjusted in contending with their caregiving responsibilities, less likely to view caregiving as an intrusion, and more satisfied with their experience than Caucasian caregivers. In addition, African-American caregivers find it easier to cope with the caregiving role, are more adaptive to complications resulting from the illness, and look upon caregiving as an obligation or expectation rather than a burden (Richardson & Sistler, 1999).

The ability of African-American to cope well under a stressful life situation such as caregiving may be attributed to their history of discrimination and deprivation. In other words, because African-Americans have been forced to face difficult life events

historically, they may have developed effective coping strategies, such as prayer, religion, and informal support, which are beneficial in their roles as caregivers. The African-American value system encourages the unity of family, kinship responsibility, respect for the older generations, and prominence of religious institutions and spirituality (Richardson & Sistler, 1999). Segall and Wkyle (1989) reported that religion was the major form of coping among African-American caregivers. More than eight in ten (84%) African-American caregivers say they cope with caregiving stress by praying (NAC & AARP, 2004).

The African-American extended family is highly integrated and heavily associated by frequent interaction among family members, close affective bonds, and exchange of goods and services between members. Their strong kinship network emphasizes togetherness, cultural traditions and the importance of family over individual. In addition, African-Americans tend to develop ties with their families on whom they can depend for emotional, social, and practical support. The strong presence of extended family influences a great use of informal support networks. As a result, former services such as support groups and nursing facilities are underutilized by African-American because of culture-based values which promote shared residence, well functioning kinship groups, and informal supports (Richardson & Sistler, 1999). African-American families are more likely to provide care for the elderly in their residence than place the disabled adult in a skilled nursing facility.

Historically, most dementia caregiving studies focused on the majority population (Connell & Gibson, 1997). However, Picot (1995a) studied African-American

Alzheimer's disease caregivers and found that the most frequently reported reward was the belief that "God will bless." Picot also found perceived rewards to be related to use of coping strategy, which relies on prayer and faith in God (Picot, 1995b). Roff, et al., (2004) examined differences in positive aspects of caregiving (PAC) among African-American and Caucasian caregivers of individuals with Alzheimer's disease participating in the National Institutes of Health Resources for Enhancing Alzheimer's Care Health (REACH) study. Their findings suggested that higher PAC among African-American caregivers appears to be partially attributable to their lower levels of anxiety and bother by recipient's behavior than Caucasian caregivers. African-American' more positive appraisals of caregiving were also related to their lower level (53 %) of socioeconomic status (SES) as compared to the Caucasian (65 %) caregivers. Roff and his colleagues (2004) coded the primary employment situations of both the caregiver and his or her spouse (either currently or before retirement) by using the Nam-Powers Socioeconomic Status Scores (Nam & Terrie, 1988), and they used the higher of the two to determine SES Scores, scores could range from 0 to 100. Thus, the results of this study suggest that African-American caregivers express more positive appraisal of caregiving than their Caucasian counterparts and that religiosity partially mediates this relationship (Roff, et al., 2004).

NAC and AARP (2004) reported that more than one in three (35%) African-American caregivers say they spend one to eight hours per week providing care. They are more likely to spend 9-20 hours a week providing care. African-American

caregivers were identified as more likely to be single, never married, or employed compared to Caucasian or Hispanic caregivers.

African-American caregivers are more likely than Caucasian caregivers to say that caregiving is a financial hardship. Therefore, it is not surprising that they asked for information on how to get financial help for the care recipient. Socioeconomic factors such as the amount of money caregivers spend on care recipients' needs and caregivers' lower educational attainment appear to increase caregiver risk for financial hardship for some caregivers. African-American caregivers appeared to be more disadvantaged as a result of these factors (NAC & AARP, 2004).

The History of African Americans and Caregiving

Royse and Turner (1980) stated that since the publication of Frazier's (1966) classic studies of black family life, researchers often maintained there is more pathology in black families than white families. Royse and Turner also reported that this pathology focus was characterized in the controversial Moynihan (1965) report. Moynihan reported as evidence of greater dysfunctioning in black families the high incidence of illegitimate births, households headed by females, welfare enrollment, and broken marriages. In response to Moynihan, Hill (1971) responded by analyzing and interpreting census data and other types of information and identified five strengths found in black families: 1) strong kinship bonds, 2) work orientation, 3) adaptability for family roles, 4) achievement, and 5) religious orientation (Royse & Turner, 1980).

In response to Hill's (1971) five strengths found in black families, Royse and Turner (1980) conducted a study based on the list of the strengths and on a review of the

literature on black families. They identified twelve census tracts in Dayton, Ohio, containing the highest concentration of blacks. Random selection of four of these tracts and of fifty blocks within the four tracts, Black households were randomly selected, and one adult resident from each household ($N = 128$) was interviewed. The results of the finding suggested that Blacks perceive themselves to have the same family strengths as those identified by Hill (1971). However, Royse and Turner (1980) concluded that is necessary to note that some of the characteristics outlined in these studies as family strengths can also act as detriments. For example, a family's financial resources can suffer when too many children or elderly relatives are taken in.

According to Willie (1994), Billingsley (1994) described the African-American Family as a resilient and adaptive institution. This stability and strength can be traced back to their African heritage and culture. Additionally, Billingsley used census data and data derived from the 1979/80 University of Michigan National Survey of Black Americans and reported that a high level of egalitarian relations existed among African-American families. He also reported that black women were prominent in the provider role and made great contributions to the economic viability of their families, and that less than 10 percent of African-American families consisted of a husband and wife were supported by earnings from the wife's employment only. However, in 1994, Billingsley reported a decreasing proportion of two-parent African-American families and counseled us to examine the increasing proportion of multigenerational, extended and blended families in which 90 percent of black babies born out of wedlock are reared. In sum, African-American families and their experiences are diversified.

The strong will African-Americans to provide quality in-home care to their elders can be traced back to the strong family ties of their African ancestors-heritage. Martin and Martin (1985) stated that even though the African societies and tribes were diverse, they shared a lifestyle centered on the family. Smaller family units (nuclear families) would often become apart of a larger extended family network, and the larger family network would often make up a clan, and several clans would make up the entire tribe or community. The traditional African kinship system was an advanced social structure that linked groups, families, and individuals to each other. This traditional African kinship system formed the basis for caregiving.

The helping tradition among African families meant that every member of the family had to have enough to eat, some simple covering, and a place to sleep. The family members viewed themselves as one in order to function and survive as a unit (Martin & Marin, 1985).

How has the helping tradition of Africans carried over into black life in America? According to Martin and Martin (1985), slavery of Africans inadvertently reinforced the African helping tradition. The deleterious forces of slavery destroyed the traditional African family by uprooting this strong family unit from its native land, but it did not destroy the strong feeling for family that the slaves had deep within their souls. If anything it enhanced the strong sense of family. In addition, the extended family contributed to the basis of the black helping tradition found among slaves. Gutman (1976) concluded that four crucial elements of family among the slaves were the development of caregiving in the slave community: 1) the breakdown of patriarchy and

the concomitant rise of black male-female equality and cooperation, 2) the mutual-aid network, 3) the pro-socialization of children, and 4) status-group cooperation.

Fictive kinship grew strong during the times of slavery. In other words, everybody in the community was treated like kin (relatives). An individual did not have to be a relative by blood or marriage to receive help from other slaves, especially the elderly. When the older slaves could no longer work as hard as they could when they were younger, the young slaves would help the older slaves do their work or meet their quotas. At times, when old slaves were unable to work because of illness, blindness, or just old age, they were often left to "fend for themselves". However, the strong sense of kinship made the life of the old slaves easier to bear. As in traditional Africa, the elders were looked up to and respected in the slave community. They were given an honorable place in the family and were often viewed as the heads of the slave families (Martin & Martin, 1985).

According to Martin and Martin (1985), the Bureau of Refuges, Freedmen and Abandoned Lands (Freedmen's Bureau) was instrumental in providing clothing, shelter, medical care, tools, and education to thousands of emancipated blacks. Many illiterate, impoverished black people donated funds to help other blacks. A great portion of their contributions went into the care of the elderly. During this period, the benevolent societies, fraternal orders, and secret societies that had previously addressed themselves largely to the needs of free blacks in the pre-Civil War period were reactivated to deal with the needs of emancipated slaves and once again, they became ubiquitous in the black community. During the Reconstruction period, the benevolent societies and the

fraternal orders were in their highest historical stage of caring for ex-slaves and other destitute blacks.

Dilworth-Anderson and Rhoden (2000) reported that during and after the transition from slavery to a post-emancipation rural agricultural economy in the South, the status of women as central to family and community continued to be linked to their role as caregivers. Their role as caregivers remained dominant during the period when African-American women in the family and community moved from a southern agricultural setting and economy to northern urban industrial areas. Many African-American women worked outside the home due to economic necessity and worked in the home as caregivers to husbands and children. The caregiving tradition continued, both within the family and the African-American community in general. Families continued to survive through the strength and support of mothers, extended family relationships, and women-centered cooperative child-care arrangements.

According to Martin and Martin (1985), the primary institution for helping and caring among the free blacks was the extended family. Family members helped each other emotionally, materially, and spiritually. The presence of the black church was second only to the black extended family as a caregiving institution in the free black community. Black churches grew out of the extreme religious consciousness of slave and non-slave blacks. In return, religious consciousness, like fictive kinship ties and racial consciousness was a key factor for spreading caregiving from the family to the community.

DuBois (1899) discussed the use of other institutions that provided care for black people. The chief Negro institutions of Philadelphia, Pennsylvania during the late 1800's were: 1) The Home of Aged and Infirm Colored People, 2) the Douglass Hospital and Training School, 3) the Woman's Exchange and Girl's Home, 4) three cemetery companies, 5) the Home for the Homeless, 6) the special schools such as the Institute for Colored Youth, the House of Industry, Raspberry street schools and Jones's school for girls, 7) the Y.M.C.A., and 8) University Extension Centre.

The Home for the Aged of Philadelphia was a good example of the strength and power of the Black Helping Tradition. It was founded in 1864 by a Negro lumber merchant, Steven Smith, and it was conducted by whites and Negroes. During the late 1800's it was one of the best institutions of its kind; its property value was \$400,000, and it had an annual income of \$20,000. It had sheltered 558 old people by the year 1889 (DuBois, 1899).

Even though the helping tradition heritage declined during the Great Depression of the 1930's, it grew stronger during the 1960's civil rights movement, especially in both rural and urban areas of the United States. Even the migration of blacks from rural to urban areas found the helping tradition in operation when members of the extended families migrated to the cities and paved way for others. Black caregiving was just as powerful in the cities as it was in rural and small towns, and life in the big cities demanded even more new efforts. However, by the mid 1970's, the helping tradition was barely surviving - largely because it had not been institutionalized (Martin & Martin, 1985).

Despite many transitions and years of struggle and oppression, the black helping tradition survived and became a strong force within the Black community. Martin and Martin (2002) defined the Black helping tradition as the largely independent struggle of Black people to collectively promote their survival and advancement from one generation to the next. The caregiving personality in the Black helping tradition is a spiritualized, socialized, and racialized personality seeking psychic stability and wholeness and promoting a sense of “we-ness” among the people. Spirituality, racial identity and worth, and communal action go together as the pillars of the Black helping tradition. The spiritual experience attached Black people to their place and role in the world and determined the extent to which they felt a sense of commitment to the well-being and uplift of Black people.

Stewart (2007) examined the influences of African-American migration on the development and functioning of African-American families and family relationships. This researcher combined existing literature and information gathered during an ethnographic study at large. The study was conducted during 2001-2002 and it examined the migration patterns of African-Americans. Stewart (2007) reported that the direction of the migration has been dependent on a variety of social, economic, and historical factors; focusing on migration that occurred between northern and southern locations. This study identified the following patterns of African-American migration: Leaving the South in search of economic stability (1900-1970); and returning to the South (1970 to present). In sum, in 1900, about 90 percent of African-American lived in the South, but by 1970 that number had dropped to 53 percent (Stewart, 2007).

According to Stewart (2007), the typical definition of migration refers to physical movement. However, broader definitions of migration have had significant effects on African Americans in more recent years. For example, migration can be viewed in terms of physical, social, or economic distance. Historically, Migration of family members led to not only greater economic resources but also greater exposure in terms of educational and social experiences. Socioeconomic or physical mobility exposed the African-American family to different values, behaviors, and different people. This exposure seemed clearer as the African-American middle class has grown.

Finally, the findings in Stewart's (2007) study suggest that throughout the history of African Americans' migration, a sense of tradition and cultural values and norms was maintained. However, in the conclusion of this study, Stewart (2007) reported the following:

Today, migration takes on broader definitions, and these definitions and implications of those movements in socioeconomic and educational status coup represent the next chapter in the migration experience of African-Americans. This is particularly important as one examines the needs and expectations of aging African-American who were previously able to rely on familial support systems to provide various types of care. Those systems may now prove to be unavailable due to issues of physical proximity or the impact of exposure to value systems that privilege individual attainment and nuclear family structure over resource sharing and extended family obligation (p. 61).

African-American Elderly

According to the Administration on Aging (2006), the African-American older population is living longer. In 2004, the African-American older population was 3.0 million and made up 8.2 percent of the total older population. By 2050, it is projected that the older African-American population will grow to 10.4 million and account for 12

percent of the older population. In 2004, almost 50% of older African-American lived in eight different states: New York (9.2%), California (6.6%), Florida (6.5%), Texas (6.2%), Georgia (5.6%), Illinois (5.6%), North Carolina (5.4%), and Virginia (5.3%) (Administration on Aging, 2006).

The poverty rate for older African-American is more than twice that of all older adults (23.9 percent and 10.4 percent respectively). If older African-American that fall below poverty did not have Social Security Benefits, they would increase their poverty rate from 23.9 percent to 58.2 percent. Almost 28 percent of older African-American women live below poverty (Beedon & Wu, 2004). In 2004, households headed by African-American 65 years and older reported a median income of \$26,282, compared to households headed by all other older adults who reported \$35,825. The median personal income reported by older African-American men was \$14,960 and \$9,884 for older African-American women, compared to \$22,102 personal income for all other older men and \$12,080 for all other older women (Administration on Aging, 2006).

In reference to health, about 63 percent of African-American older men and 60 percent of African-American women reported good or excellent health in 2002. Since positive health evaluations decline with age, forty-five percent of African-American 85 years of age and older reported good or excellent health that same year. However, African-American older adults have at least one chronic condition and many have multiple conditions. The following conditions occurred among this population during 2002-2003: Hypertension (68%), diagnosed arthritis (53%), heart disease (25%), diabetes (25%), sinusitis (15%), and cancer (11%). These figures are compared to all

other older adults: Hypertension (51%), diagnosed arthritis (48%), heart disease (31%), sinusitis (14%), diabetes (16 %), and cancer (21%) (Administration on Aging, 2006).

The Administration on Aging (2006) reported that 73 % of African-American older adults had no health insurance in addition to Medicare while 37% of all other older adults lacked such insurance in 2003. In addition, 96 % of African-American older adults reported that they did not have a usual source of care and 17 % reported that they or a family member was unable to obtain or was delayed in receiving needed medical care. In 2004, State and Area Agencies on Aging reported providing services to 8.0 million adults aged 60 and older. Even though these agencies placed emphasis on providing services to persons with the greatest social and economic need, including members of ethnic minority groups, especially the poor; only 11 percent of their recipients were the African-American elderly.

Positive characteristics of African-American elders may suggest that their aging experiences are wonderful. However, social problems such as poverty, lack of access to services, and racially and culturally insensitive services can paint a different picture for older African-American. Fifty percent of all African-American older adults live in poverty (Rasheed & Rasheed, 2003). African-American elders also experience low literacy levels, poor and chronic health conditions, lack of transportation and limited housing (Wan, 1977; Wood & Wan, 1993). Such factors increase the lack of knowledge of, access to, and the ability to afford services (Rasheed & Rasheed, 2003).

Harris and Guten (1979) defined health protective behavior as behavior performed by a person regardless of their perceived health status, in order to protect, promote or maintain his/her health regardless of whether such behavior is effective.

African-American elders' health protective behaviors are supported by their cultural ethos and spiritual beliefs. They choose to rely on their religious faith to protect health rather than traditional medicine or formal health care systems. There is a cultural belief that to be physically mobile is a sign of health in spite of biological and medical disturbances (Rasheed & Rasheed, 2003).

Historically, in the African-American culture, elders were well respected and honored because African-Americans believe that with age comes wisdom and respect. The black church continues to be the most powerful institution in the African-American community. It provides the spiritual, emotional, and existential meaning for African-American and it symbolizes the heart and soul of the community. The African-American church has become an alternative social service agency for many African-American elders who reside in rural areas. When community senior services are not available for both white and black elders, African-American older adults are more likely to turn to their church for assistance than their Caucasian cohorts (Rasheed & Rasheed, 2003).

Even though there is a strong culture among African-American elders that rely on folk beliefs, self-help, and self-care, there is also a strong presence of social support networks that includes informal support and care systems that consist of family and/or community-based services (Carlton-LaNey, 1992). These elders rely on spouses, children, siblings, friends, neighbors, and the community church due to their experiences

with racism, discrimination, and personal histories of encountering injustices from formal support systems of care (Rasheed & Rasheed, 2003). In addition, health care and transportation services are provided informally by relatives and friends in order to allow the elder to live the rest of his/her life at home and in the community (Wood & Wan, 1993). Rasheed and Rasheed (2003) reported that in spite of the fact that many African-American elders' caregivers are themselves likely to be poor, the African-American sense of community and the black helping tradition persist as the cultural foundation for providing informal care to older African-American residing in their communities.

African Americans and Religiosity/Spirituality

What is religiosity (religion) and spirituality? It is important to describe the similarities and differences that interlock these two concepts. Koenig, McCullough, and Larson (2001) defined religion as an organized system of beliefs, practices, and rituals designed to incorporate a intimate relationship with God, whereas, spirituality can be viewed as a personal quest for understanding answers to ultimate questions about life, meaning, and relationships to the sacred. Religiosity (religion) is more community focused, formal, organized, and behaviorally oriented, whereas, spirituality is more personal, less visible, more subjective, less formal, less systematic, and more emotionally based. Pargament and his colleagues (1998), combined these two concepts and defined religious/spiritual coping as religious and/or spiritual methods of coping that affect the psychological, social, physical, and spiritual adjustment of people to crises, for better or worse.

Taylor, Chatters & Levin (2001) reported that for over 100 years there has been ongoing academic interest in the nature, patterns, and functions of religion in the lives of African-American that is reflected in the study of history, religion, and sociology. Scholars are fascinated with the religion of African-American because it has survived difficult times and profound circumstances throughout time. African-Americans have also survived a long history of racism, prejudice, poverty, and discrimination. However, their black religious tradition and the Black Church have remained resilient and grounded in the lives of individuals, families, and communities.

According to Taylor, Chatters, and Levin (2001), religion in the lives of African-American is multifaceted, complex, and diverse. Their faith has many avenues of expression through church services, public and private behaviors, attitudes, and beliefs. "African-American religious life, in all forms, is vibrant, creative, and resourceful testament to the power of faith to uplift and sustain in the face of prejudice, discrimination, and exclusion" (Taylor, Chatters & Levin, 2001, p.11).

In their study of the role of religion in the lives of African-American, Taylor, Chatters, and Levin (2004) reports that are characteristics that distinguish the distinction between religiosity (religion) and spirituality. Religion is more community focused, formal, organized, and behaviorally oriented; whereas, spirituality is more individualistic, less visible, more subjective, less formal, less systematic, and more emotionally oriented. Prayer is used more frequently than any other form of religious expression. Additionally, their research also suggests that a significant amount of African-Americans who do not identify a specific denomination or attend religious services still continue to pray on a

frequent basis. African-Americans request prayer from others less often than they pray for themselves. However, they will ask for others to pray for them when they are faced with an individual problem or encounter a situation in which there is an expressed need for prayer (Taylor, Chatters & Levin, 2001).

Levin, Chatters, and Taylor (1995) studied the relationship between religion and life satisfaction among African-American, using the National Survey of Black Americans. They found that organizational religious activities were associated with both better health and greater life satisfaction. Handal, Black-Lopez, and Morgen (1989) studied the relationship of religion and emotional pain among African-American women. The findings suggested that those with moderate or high religious faith were less likely to suffer psychological distress than those who scored low on a standard test of religiosity.

Koenig (1999) reported that African-American show an amazing ability to cope with stress despite their historically encounters with discrimination, rural and urban poverty, and the violence experience in inner cities. Throughout his research, Koenig (1999) observed the marked tranquility among older black patients. He witnessed that elderly men and women often made reference to the role of God and faith in their lives.

According to Pargament and Brant (1998), very few studies have compared the helpfulness of religion to different groups faced with negative life situations. However, African-Americans who were given a national survey were asked to indicate the one coping response that helped them the most in dealing with a serious personal problem. Overall, 44% said that prayer was the one coping response that helped them the most. Krause and Chatters (2005) tested the differences in 17 different measures of prayer

among Caucasian and African-American elders by assessing five dimensions of prayer:

1) the social context of prayer, 2) the substantive context of prayer, 3) the length of prayer, 4) interpersonal aspects of prayer, and 5) beliefs about prayer operates. The findings suggested that older African Americans are more deeply involved than older Caucasians in 16 of the 17 prayer measures.

Wallace and Bergeman (2002) used a life history, qualitative approach to examine the various mechanisms through which spirituality and religiosity served as protective function among African-American elders. This study suggested that coping through prayer and faith, as well as participation in formal and informal activities of the church and synagogue, is critical to the preservation of the self among most persons who belong to the current cohort of the oldest old. The findings also suggested that religious activity fostered more positive self-perceptions in African-American, particularly for individuals with physical limitations.

Black (1999) interviewed fifty elderly African-American women living in poverty to explore how their spirituality informs their ability to cope with poverty. The results of the study yielded a key theme emerging from the women's narratives that their relationship with God, perceived as personal, reciprocal, and empowering allowed them to take an active and positive role in viewing and interpreting the circumstances of their lives. The women's self-concept, their opinion of others, and their purpose in life were guided by their belief in God's individual, intimate, and ultimate concern for them.

Spirituality is an essential part of the African-American community (Plante & Sharma, 2001). Frame And Williams (1996) described spirituality as the "whole of life"

for many African-American. In a 1998 study, the well-being components of life purpose and satisfaction were directly related to either or both the individual's relationship with God and an active religious life (Fleming & Anderson, 1998).

Martin and Martin (2002) stated that when African Americans are spiritually centered, their spiritual lives are in harmony with their culture. If their culture is a caring, empathic culture then their spiritual lives and behavior will reflect their true culture. When African Americans are spiritually centered there is a balance between spirituality and culture. Spirituality is so important in African-American culture that when spiritual fragmentation is present culture fragmentation is also present. Therefore, when spirituality is not apart of their culture, African Americans suffer not only from spiritual fragmentation but also from spiritual alienation.

In order to address the impact of Christianity and religion on African-American values and coping skills we must view the impact of Black leadership and the Black Church. The Black Church has played and continues to play an active role in the lives of African-Americans. God is seen as a God of love, strength, and forgiveness. These attributes are emphasized in religious practices in the Black Church and they are just a few of the religious beliefs that influence the spiritual lives of African-American.

Malone (1994) reported that there are two types of Black churches: The sanctuary-bound, non-liberation church and the liberation church. He stated the sanctuary-bound non-liberation church fails to see that God is involved in all of life because worship is relegated only to the sanctuary. It fails to recognize all of life as sacred and divides life into sacred and secular dimensions. The non-liberation Black

church is only concerned about going to heaven. In contrast, the liberation church defines salvation as deliverance from personal sin and corporate sin. Worship is viewed not only as an encounter with God in the sanctuary, but also as a call and challenge to get involved in community life. This form of religion practiced by African-American uses the expression "wholistic ministry" because it seeks to minister to people spiritually, physically, mentally, emotionally, socially, and economically.

Wimberly and Wimberly (1995) described pastoral care as contextual responses of agape (Godly) love by caring people who understand themselves to be related significantly to God. Additionally, they defined pastoral care (also known as congregational care) as the actual direct caring response by others to a person facing life transitions and life crises. These supportive and nurturing networks are part of the church ministry that often assists in the provision of resources for older African Americans.

According to Wimberly (2003), congregational care in the lives of African-American older adults is the Black Church's efforts to honor their elders' need (a variety of care) and respond to their desires to contribute to congregational life to the extent they are able. It is important to note that congregational care that takes into account this dual emphasis lies in the fact that the Black Church remains the primary, if not only, voluntary association to which many African-American older adults belong. African-American elders are more likely than other age group to be members and supporters of congregations. Congregational care emphasizes that God desires health and wholeness for all people and that human life is precious and all God's people yearn for

love, honor, respect, and care. Therefore, African-American congregations recognize that like others, their elders seek an ongoing sense of well-being.

A rural 78 year old African-American woman describes the importance of the Black Church (Carlton-LaNey, 2005): "As the years grew a little better, our main goal during them days was going to church, Sunday School, and back to church. That's where you saw everybody. Get out of church and everybody would be talking, shaking hands, ha ha, everybody would be glad to see one another" (p. 59).

Religiosity/Spirituality and Health

Recent studies have shown how religion and spirituality influence physical and mental health. Koenig (1997) reviewed over ten research studies and found that religiosity (religion) has a positive effect on health. Religion as used in his study, includes depth of belief in and commitment to God; frequency of prayer, scripture reading, church or synagogue attendance; and the use of these beliefs and practices when coping with stress. He found that four out of ten patients admitted to a tertiary-care teaching hospital believed religion was the most important factor that helped them to cope. Studies examining the relationship between religion and health have become increasingly of interest to social, behavioral, and health researchers (Chatters, 2000).

Chatters (2000) reviewed studies that examined the relationships between religion and the health of individuals and populations. Better physical health status, as measured by a variety of indicators, is moderately associated with higher levels of religious involvement, even when defined by numerous indicators and examined with diverse groups within the population. Evidence concerning the impact of religion on mental

health indicates strong positive associations between religious involvement and mental health outcomes. The studies also supported research that indicates that religion is beneficial to a sense of personal well-being and overall adjustment. Individuals who use religious coping appeared to handle their problems more effectively than those who did not use this coping mechanism.

Armstrong and Crowther (2002) examined research findings that identified the effects of spirituality on physical and mental health among older African Americans. From their perspective, spirituality is a relationship with a transcendent force that brings meaning and purpose to one's existence, and affects the way in which one operates in the world. The results of this study suggested that there is a positive relationship between spirituality, physical, and psychological outcomes.

Moberg (2005) reviewed research investigations that indicate age differences point to the likelihood that spirituality tends to increase during later adulthood. Spirituality has positive influence on life satisfaction, psychosocial well-being, and both physical and mental health. It is beneficial to therapy for recovery from illness and is a source of meaning and purpose in life. Spiritual inventions can be used to relieve psychological distress and death anxiety, as well as the stresses of caregiving. The power of prayer is a much used resource for coping with problems experienced during the life span.

Individuals who are more spiritual and religious have a lifestyle that reduces mortality. They are less likely than others to use tobacco, abuse alcohol or drugs, engage in premarital sex and adultery, become divorced, and have habits harmful to health. They

are more likely to use a social support network and to experience serenity and peace with others, themselves, and God (Moberg, 2001).

Marks, Nesteruk, Swanson, Garrison, and Davis (2005) examined the association between highly religious activities and longevity among African-Americans by reviewing six themes: active faith involvement and the aged, avoiding negative coping, evading violence, the absence of hope, social support, and the power of prayer. The results suggested that active religious involvement during the advanced years promotes longevity by offering respect, veneration, and meaning to the participants.

Is religiosity always good for health? Most medical doctors view religion as harmless but irrelevant to health or health care. Additionally, a substantial number of mental health professionals argued that religion has a neurotic influence that breeds mental inflexibility, emotional instability, emotional instability, and unhealthy regression of natural instincts. For example, Sigmund Freud (the father of modern psychiatry) argued convincingly that religion (religious commitment, beliefs, and practices) was linked with neurosis. He rationalized that therapy would reduce the need for religion and increase the need for human reasoning (Koenig, 1997).

Dr. Albert Ellis made outstanding contributions to the development of cognitive-behavioral therapy, a psychotherapeutic technique for treating depression, anxiety, and other emotional disorders. However, Ellis believed that the practice of religiosity (devout and orthodox religion) was in many respects equivalent to irrational thinking and emotional disturbance (Koenig, 1997).

Stress and African-American Caregiving

Older adults are living longer than their predecessors (President's Council on Bioethics, 2005). Chronic illness and functional disability, rather than acute illness, are both major factors in the health and quality of life among older adults. Furthermore, it is not surprising that the percentages of disability and difficulty with performing activities of daily living increase as the elderly grow older (NASW, 2003).

Caregiver research has increased understanding about the impact of chronic illness in families and it has explored the complex relationships between stress and human responses (psychological and physiological) in the context of aging, identifying caregiving as a chronic stressor (Vitaliano, et al., 2004). According to Leblanc (2004) and his colleagues, care-related stress can have deleterious effects on the health of informal caregivers.

Folkman and Lazarus (1988) studied the relationship between coping and emotion and concluded that historically, coping has been viewed as a response to emotion. According to Folkman and Lazarus' Stress-Process Model (1986), the relationship between the stressful events that a person encounters in daily living and emotional outcomes is mediated by two processes: cognitive appraisal and coping.

Religious/Spiritual coping can be examined as a coping mechanism used during stressful life events. This assumption is based on various studies that reported that increased stress motivated the engagement of religious coping (Folkman, Chesney, Cooke, Broccellarie, & Collette, 1994; Kaye & Robinson, 1994; Salts, Denham, & Smith, 1991; Wheaton, 1985).

Meichenbaum and Fitzpatrick (1993) stated that religious coping can be viewed in various ways, including turning to God as a basis of trust, faith, engaging in prayer, confession, turning to clergy or to a congregation for support, and focusing on the world to come. Pargament (1990) described how religious belief, faith, and rituals influence religious coping. He reported that an individual's faith and religious involvement can make stressful life events more bearable and provide a meaningful, coherent explanation and orderliness to such events. This force of religious practice may also provide a sense of hope and comfort, as well as established guidelines on how to handle stressful events. More important, an individual's religious beliefs and faith can nurture a sense of belonging by promoting identity and a sense of intimacy and support with both God and with a religious community.

African-American caregivers are more likely to provide higher levels of care, to have higher levels of self-efficacy and gains in relations to caregiving, and to be economically disadvantaged than their white counterparts (Hooyman & Kiyak, 2005). Researchers have reported that African-Americans' use of religious coping strategies may account for differences in overall appraisals of their experience (Connell & Gibson, 1997). Taylor, Chatters & Levin (2004) review of literature suggested that religious beliefs and coping strategies are relevant for understanding several aspects of the African-American caregiving experience, including primary appraisal processes.

A number of researchers have found that religiosity/spirituality is most likely to have a positive impact on caregivers' health (Baines, 1984; Kaye & Robinson, 1994; Quayhagen & Quayhagen, 1988; Rabins, Fitting, Eastham, & Fetting, 1990; Stolley,

Buckwalter, & Koenig, 1999). Religious/spiritual coping has been expressed as daily spiritual experiences, meaning, values, beliefs, forgiveness, private religious practices, religious/spiritual coping, religious support, religious/spiritual history, commitment, organizational religiousness and religious preference (Leblanc, et al., 2004). Caregivers who used religion or spiritual beliefs to cope with the stress of caregiving were more likely to have a good quality relationship with the care recipient. This good quality relationship was associated with less depression among caregivers (Chang, et al., 1998).

Pinquart and Sorensen (2005) examined ethnic differences (Caucasian, African Americans, Asian Americans, and Hispanics) in caregiver background variables, objective stressors, filial obligation beliefs, psychological and social resources, coping processes, and psychological and physical health. Their results suggested that African-American caregivers had lower levels of caregiver burden and depression than Caucasian caregivers. Pierce (2001) examined how spirituality aspects of caring affect caregivers' well-being and African America families' functioning. Eight themes concerning spirituality for all caregivers emerged from this study: a filial ethereal value, self-contemplation, motivation for a philosophical introspection, filial piety, living in the moment and hoping for the future, purpose, motivation that came from approval by care recipients, and Christian piety. Through spirituality, the caregivers reported well-being and a sense of connection and comfort in difficult times related to caregiving.

Stuckey (2001) stated that increasing attention in the scientific research has focused on the relationships among religion, spirituality, and overall well-being. Investigators identified religion and spirituality as significant coping resources

throughout the life course. He studied a group of Catholic and Protestant older adults who were both caregivers and non-caregivers in order to examine their views of religion, spirituality, and how they integrated their faith into their lives. The purpose of his study was to learn more about how persons of faith, when confronted with traumatic life events, are able to transcend crisis and maintain a sense of hope and purpose rather than falling into despair. All participants spoke of how they relied on their religious and spiritual beliefs and practices, particularly prayer, as coping resources throughout their lives.

Pargament, Smith, Koenig, and Perez (1998) examined positive and negative patterns of religious coping methods and implications for health and adjustment. They identified religious coping as multidimensional and stated that such a mechanism is designed to assist people in the search for a variety of significant ends in stressful times; a sense of meaning and purpose, emotional comfort, personal control, intimacy with others, physical health, or spirituality. The results of this study suggested that the positive religious coping patterns was linked to benevolent outcomes, including fewer symptoms of psychological distress, reports of psychological and spiritual growth as a result of the stressor, and interviewer ratings of greater cooperativeness. In contrast, the negative religious coping pattern was associated with signs of emotional distress, such as depression, poorer quality of life, psychological symptoms, and callousness toward others.

In reference to the physical and mental health outcomes of Pargament, Smith, Koenig, and Perez's study (1998), the greater use of positive religious coping was slightly related to more medical diagnoses, poorer functional status, and poorer cognitive

status. Positive religious coping was not related to illness severity or subjective health status. Small but significant associations were found between greater use of negative religious coping and more medical diagnoses, poorer functional status, poorer subjective health status, and poorer cognitive status. Negative religious coping was not related to illness severity. However, the greater use of positive religious coping was moderately associated with greater cooperativeness, and strongly tied to higher levels of stress related growth, and more religious outcomes. Positive religious coping was not related to depression or quality of life. Greater use of negative religious coping was moderately related to higher levels of depression and lower quality of life, and slightly associated with higher levels of stress-related growth, and more positive religious outcomes. In sum, the findings yielded reports that religion can be identified as a source of distress as well as a source of solutions in coping.

Stress and Coping

Stress is a process in which stressors, appraisal coping, and stress reactions are the main components. It occurs when an individual perceives the environmental demands as exceeding her/his appraised capabilities (Vingerhoets, 2004). Lazarus and Folkman (1984) describe stress as a relationship between the person and the environment in which characteristics of the person are one important component, and the nature of the environmental event is another. Therefore, it is important to study stress because it causes psychological distress and leads to changes in the body that may have acute or chronic consequences on an individual's health (Taylor, 1999).

When an individual is faced with a stressful event, and he/she fails to use effective coping mechanisms, he/she will encounter stressors (stimuli) that lead to anxiety (Barker, 2003). According to Vingerhoets (2004), stressors occur in many different life situations (e.g., work, social relations, family, society, and nature). Disease can be conceived of as a stressor associated with the self, and it can increase the likelihood of being susceptible to stressors in other life events.

Cohen and his colleagues (1998) studied types of stressors that increase susceptibility to the common cold in healthy adults. They concluded that individuals who experience chronic stressors associated with marked or severe long-term threats were two and three times more likely to develop colds than those without such stressful events. Their results suggest that chronic stressors may be associated with more than one disease process. Leventhal, Patrick-Miller, and Leventhal (1998) reported that Cohen and his colleagues provided research that supported the powerful and valid hypothesis that life stress can damage an individual's health.

Whether chronic or acute, stress can increase the risk of both physical disease and psychiatric illness. Matthews, Gump, and Owens' (2001) study of middle-aged healthy adults who reported high levels of chronic stress exhibited suppressed cardiovascular and neuroendocrine responses during acute stress and recovery, adjusting for baseline levels of function. Although the majority of the participants of this study were middle class (based in education, income and employment status) Caucasian men (90 %) and women (81 %), the findings suggested that, to some extent, chronic stress affected the physiological responses of men to a greater extent than those of women.

Coping can be defined as "the constantly changing and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person" (Lazarus & Folkman, 1984, p.141). Sperling (2003) reported that coping always includes a variety of responses and concluded that coping behavior can be specific to particular life domains in middle adulthood and young-old age. The results indicated that coping behavior can develop differentially in response to domain-specific demands of everyday life. Classen, Koopman, Agnell, and Spiegel (1996) identified coping strategies associated with psychological adjustment to advanced breast cancer. They reported that more emotional distress was associated with the less likelihood of adopting a fighting spirit and associated with more use of emotional control strategies. The study also yielded strong evidence that emotional control is associated with lower levels of psychological adjustment among advanced breast cancer patients.

According to Stone and Kennedy-Moore (1992), instruments that assess situational coping enhance the understanding of how psychosocial factors affect health. Williamson's (2000) study of breast cancer patients supported and confirmed the extension of the Activity Restriction Model of Depressed Affect. The findings clarified and supported the indication that the restriction of normal activities is a major factor in depressed affect. Williamson reported that illness severity was directly related to greater restriction of routine activities, and that more activity restriction was associated with higher public self-consciousness and less social support.

Stress can have a profound effect on an individual's health, especially on his/her immune system. However, over 85 intervention studies report that psychological interventions can modulate the immune response in humans, and these studies present a series of models representing the psychological pathways through which this might occur (Miller & Cohen, 2001). Miller and Cohen's (2001) meta-analysis reported that disclosure interventions showed some evidence of success to alter immune change. Disclosure intervention facilitates a less threatening approach, encouraging the individual to disclose feelings in order to cope with a stressful life event. This psychological intervention could be explored by studying its usefulness as a coping strategy with regard to other stressful life situations such as informal caregiving of older adults.

Coping Styles

According to Taylor (1999), coping styles consist of predispositions to cope with stressful situations in particular ways. Avoidance versus confrontation is one prominently studied coping style. Taylor (1999) stated that some people cope with a stress situation by using avoidant (minimizing) coping style, whereas others use a confrontational (vigilant) coping style by gathering information or taking direct action.

Problem-focused coping (individuals take action to change a threatening relationship between themselves and their environment) and emotion-focused coping (individuals take steps to regulate the emotional distress produced by person-environment relationship) differ from relationship-focused coping strategies. This coping style includes interpersonal regulation processes aimed at establishing, maintaining, or disrupting social relationships (Kramer, 1993).

Folkman and Lazarus (1980) analyzed the ways 100 community-residing White men and women aged 45 to 64 coped with the stressful events of daily living during one year. The study focused on two basic questions concerning the coping process. First, to what extent are people consistent in coping with the diverse stressful situations encountered during daily activities? Second, what factors influence the coping process? The results of the study concluded that both problem-and emotion focused coping were used 98% of the 1,332 episodes. They also reported that coping is best understood as being determined by the relationship between the person and the environment, rather than by independent person or situation factors. The findings of this study offered strong support for this position and demonstrated its usefulness in understanding the coping process.

Miller and Mangan (1983) developed the construct of monitoring and blunting coping styles to identify different ways people deal with stress. The styles refer to the characteristic ways that individuals respond cognitively and emotionally to potentially distressing situations. For example, if an individual encounters an aversive situation, such as major surgery, their levels of arousal depend on the amount of attention they have given to the stressor. Blunting strategies appear to be more adaptive if the stressful situation is out of the control of the individual. Whereas, monitoring strategies appear to be more adaptive if some degree of control over the situation is available (Myers, Newman, & Enomoto, 2005).

Daly, Jennings, Beckett, and Leashore (1995) identified several studies explored Africentric coping styles and problem-solving procedures. Their literature suggested that

African-American coping strategies should be reviewed through individual, family, and community functioning. They also reported that individual coping skills were established from strong value system that includes belief in self, industrious efforts, desire and motivation to achieve, religious beliefs, self-respect, and respect for others, responsibility toward one's family and community, and cooperation. In reference to coping from a family perspective, Daly and colleagues (1995) stated that influence from the extended family, neighbors, and community support systems was important to the development of resolution of family problems of African Americans.

According to Siegel and Schrimshaw, (2002) religious and spiritual beliefs and practices have been associated with greater psychological well-being among individuals with chronic illnesses. They studied 63 older HIV-infected adults who reported a variety of benefits from their religious and spiritual beliefs and practices: 1) evokes comforting emotions and feelings; 2) offers strength, empowerment, and control; 3) eases the emotional burden of the illness; (4) offers social support and a sense of belonging; 5) offers spiritual support through a personal relationship with God; 6) facilitates meaning and acceptance of the illness; 7) helps preserve health; 8) relieves the fear and uncertainty of death; and 9) facilitates self-acceptance and reduces self-blame. Their findings suggested that the participants perceived their religious/spiritual beliefs and practices as personally beneficial.

Pargament and his colleagues (1998) developed two religious coping styles to identify positive and negative patterns of religious/spiritual coping. Positive religious/spiritual coping can be expressed as a "sense of spirituality, a secure

relationship with God, a belief that there is meaning to be found in life, and a sense of spiritual connectedness with others" (Pargament et al., p. 712). These coping mechanisms are identified as benevolent religious reappraisals, collaborative religious coping, and seeking spiritual support. In contrast, negative religious/spiritual coping can be defined as an expression of "a less secure relationship with God, a tenuous and ominous view of the world, and a religious struggle in the search for significance" (Pargament et al., p. 712). This method of coping includes punitive religious reappraisals, demonic religious reappraisals, appraisals of God's powers, and spiritual discontent.

In summary, our population continues to grow older and live longer. Hence, with longevity also comes the possibility of chronic illness, limited mobility and disability among older adults. However, the majority of adults who need long-term care services and support live at home or in a community setting, receiving care from unpaid (family/friends) caregivers. Although caring for an older adult can be a very stressful life event, various coping interventions can be used to cope with the stressors associated with caregiving. One such coping style includes the use of religious and/or spiritual activities.

Finally, various studies presented in this review support the relationship between religion/spirituality and better health and life satisfaction, especially among African Americans. This minority population also has a history of providing care for elderly relatives. That's why it is important to research the role of religious/spiritual coping among African-American caregivers who provide informal care to older adults who reside in a community setting.

Theoretical Framework

According to Folkman and Lazarus' Stress-Process Model (1984), the relationship between the stressful events that a person encounters in daily living and emotional outcomes is mediated by two processes: cognitive appraisal and coping. Caregiving, for example, can be a stressful life event that caregivers encounter daily. The model includes three components: stressors, coping and outcomes. The stressor variables consist of aspects of the older adult's health problems: activities of daily living needs to be met (ADL Need) and the assistance with activities of daily living (ADL Help). The coping mechanism examined in this dissertation is the extent to which caregivers reported the use of religious/spiritual beliefs to cope. In this conceptual model, we assume that there is a relationship between stressors, and religious/spiritual coping. This assumption is based on various studies, reporting that increased stress initiates the engagement of religious coping (Folkman, Chesney, Cooke, Broccellarie, & Collette, 1994; Kaye & Robinson, 1994; Salts, Denham, & Smith, 1991; Wheaton, 1985). In these studies, general perceived stress is the outcome variable.

Chang, Noonan, and Tenndtedt (1998) used the Stress Process Models of Lazarus and Folkman (1984) and Pearlin, Mullan, Semple, and Skaff (1990) to examine how religious/spiritual coping could indirectly affect psychological distress through the quality of relationships between elders and caregivers. Pearlin and colleagues' model of stress included four components: stressors, coping, intervening variable (mediating or moderating), and outcomes. The stressor variables described three aspects of the older adult's health status consisting of level of functional disability, the presence of cognitive

impairment, and problem behaviors. To examine the coping mechanism, they measured the extent to which caregivers reported that religious/spiritual beliefs helped them make sense of their caregiving experience. The researchers assumed a direct relationship between stressors and religious/spiritual coping. Their results indicated that religious/spiritual coping affected caregivers' psychological distress indirectly through the quality of the relationship between caregivers and care recipients. Caregivers who reported using religious or spiritual beliefs to help them deal with the stressors associated with caregiving displayed better quality relationships with the older adults they cared for, which were also linked with lower levels of depression and role submersion.

Morano and King (2005) also utilized the Stress Process Models of Lazarus and Folkman (1984) and Pearlin, Mullan, Semple, and Skaff (1990) to examine the mediating effects of religiosity on caregiving strain and gain with an ethnically diverse sample of 384 Alzheimer's disease caregivers. Their hypothesis that religiosity would mediate the effects of problematic behavior on depression was not statistically significant; however, there was an indication that the role of religiosity was substantively associated with less depression. Those caregivers reporting higher levels of religiosity reported significantly lower levels of depression. Religiosity was found to be partial-mediator of problematic behavior on the caregivers' perceived self-acceptance. African Americans reported the highest level of religiosity and self-acceptance, as well as the lowest levels of depression. In addition, while the Hispanic caregivers reported slightly lower religiosity than the African-American caregivers they were still significantly higher than the White

non-Hispanic caregivers. Furthermore, African-American and Hispanic caregivers reported both lower levels of depression and greater levels of self-acceptance than the White caregivers. While the role of religiosity was not found to significantly mediate caregiving strain, the overall findings of this study indicated that religiosity is an important protective factor. Alzheimer's disease caregivers appeared to be fairing less well than either of the other two cohorts.

Schneider, Murray, Banerjee, and Mann (1999) also used the Stress Process Model of Pearlin and colleagues (1990) to conduct a cross-national study of co-resident spouse caregivers of elders with Alzheimer's disease (AD). They aimed to produce a cross-national profile of co-resident spouse caregivers across the European Community, with particular attention to: living arrangements, formal and informal support, service satisfaction, perceived burden, and psychological well-being. The study confirmed the high level of burden and mental distress in spouse caregivers for people with AD in the European Community. In addition, it suggested that there are elements of burden which may vary by country, as well as elements which have a common effect in all.

Building on the Stress-Process Model, developed by Pearlin and colleagues (1990), Goodman, Zarit, and Steiner (1997) examined how Personal Orientation affects the relationship between Primary Care-Related stressors and Primary Appraisal stressors for caregivers. This study was unique due to the addition of pre-existing Personal Orientation variables, along with the development of a multidimensional construct of Primary Appraisal stressors, or the caregivers' evaluation of caregiving. Care-Related stressors and Personal Orientation simultaneously contributed to the perception of

caregiver strain. The findings suggested that Personal Orientation in caregiving may be an important contextual factor when examining the relationship between Care-Related Stressors and caregiver Appraisals of strain.

Grafstrom, Fratiglioni, and Winblad (1994) aimed to thoroughly investigate the nature of the burden on relatives of the elderly by analyzing factors relating to caregivers and older adults that may modify burden, using the Stress-Process Model (Pearlin, et al., 1990). The results indicated that in the mild phase of dementia, long duration of the disease and decreased ADL capacity created greater burden for the caregiver.

Boerner, Schulz, and Horowitz (2004) stated that the stress and coping paradigm has most commonly been used to guide both caregiving and bereavement research. This paradigm is based on the assumption that once a stressful life event is encountered, the appraisal of the stressor, as well as mental and physical health consequences, will be a function of the unique set of risk and protective factors that an individual brings to the situation. When the link between the experience of caregiving and bereavement is considered, two opposing predictions can be derived from the stress and coping framework. Because death is preceded by prolonged stressful periods of caregiving, this may result in the depletion of coping resources, which could make the caregiver more vulnerable to the impact of the bereavement. Alternatively, the death of the care recipient may result in improved psychosocial outcomes for the caregiver because the death puts an end to the stresses of caregiving and the suffering of the care recipient (Schulz, Newsom, Fleissner, Decamp, & Nieboer, 1997).

Roff, et al. (2004) based their study on the sociocultural stress and coping model articulated by Knight, Silverstein, McCallum, and Fox (2000) in order to examine differences in Positive Aspects of Caregiving (PAC) among 275 African-American and 343 Caucasian caregivers of individuals with Alzheimer's disease from the National Institutes of Health Resources for Enhancing Alzheimer's Care Health (REACH) study sites in Birmingham, Memphis, and Philadelphia. This model defines ethnicity as a cultural variable influencing how an individual has been socialized to view caregiving. The model hypothesizes that specific strengths of the African-American family, particularly religious beliefs and traditions along with social support reinforce the value of family caregiving, thus leading to caregiver rewards. The sociocultural model of stress and coping also suggests that ethnicity might imply racial differences in the way social support would affect caregiving outcomes. Their results corroborate earlier findings that African-American caregivers express more positive appraisals of caregiving than their Caucasian counterparts and that religiosity partially mediates this relationship. In addition, the results indicated other variables contributing to the relationship between race and PAC including anxiety, behavioral bother, and socioeconomic status.

Chadiha, Adams, Biegel, Auslander, and Gutierrez (2004) gave an overview of theoretical frameworks as they applied to the empowerment of female African-American informal caregivers. They reported that rooted in the field of psychology, the stress and coping framework used to understand caregivers' stress and coping is based on work by Lazarus and Folkman's Stress Process Model (1984). According to Moos and Schaefer (1993), this framework holds those stressors and resources, as well as the ability to

appraise and cope with stressors, affect a person's health and functioning. Stressors and resources are contextual and may be located within the person and environment as well as in life-course events such as life-crises and transitions. They also stated that other aspects of the caregiving stress and coping model include the individual's appraisal of the experience as stressful or satisfying, mediators of stress such as the individual's coping styles and social support from others, and the consequences of caregiving as both positive and negative outcomes (for example, meaning, mastery, and psychological distress).

Chadiha and colleagues (2004) also stated that research on stress and coping in caregiving has led researchers to use the stress and coping framework more than any other framework for caregiving interventions. Although they did not use this framework for recommending practice strategies for female African-American caregivers, they recognized its usefulness in the development of interventions to prevent and reduce caregivers' stress. The sociocultural stress and coping model of Knight and colleagues (2000), for example, has potential for use in the development and implementation of culturally and ethnically sensitive interventions with female African-American caregivers.

Smith, Gerdner, Hall, and Buckwalter (2004) reviewed the Progressively Lowered Stress Threshold (PLST) model that was designed to promote more adaptive and functional behavior in older adults with advancing dementia. They reported that behavioral symptoms associated with dementia are a major concern for the care recipient as well as their caregivers. The knowledge and skill of formal and informal caregivers affects the quality of care they provide and their ability to cope with the challenges of

caregiving. This model teaches caregivers to monitor older adults diagnosed with Alzheimer's disease and related disorders (ADRD). The caregivers observe baseline behavior, increasingly anxious behavior as the person approaches the stress threshold, and dysfunctional behavior. Extensive research during the National Caregiver's Training Project (NCTP), a longitudinal study of 241 caregivers/care recipient dyads in five states (Iowa, Illinois, Minnesota, Arizona, and Indiana), supported the use of the PLST model in decreasing depression, diminishing uncertainty and unpredictability associated with dementia caregiving, decreasing caregiver appraisals of stress and burden while promoting levels of satisfaction, and reducing caregiver reactions to behavioral symptoms.

Pierce (2001) used the framework of systemic organization developed by Friedemann (1995) to examine caring and expressions of spirituality by urban caregivers of people with stroke in African-American families. Spirituality is a component of well-being, based on values concerning commitment, love, and affection. This theoretical framework is based on open systems principles in which the person is a system that is surrounded by an environment that is in continuous motion, and is exchanging information, energy, and matter with its subsystems and the environment. Specifically, in this model the person is defined as an open system that interacts with other people, social systems, nature, and the universe. Pierce (2001) concluded that spirituality, a component of well-being, is based on values concerning commitment, love, and affection. The researcher collected data as part of a larger study that examined the experience and meaning of caring among African-American caregivers, and how this influenced their

capacity to care for people with stroke within their family systems. The caregivers in this study reported that their outside environment was barren, but their inside environment (homes and families) was filled with people united around the caregivers. The results indicated that through spirituality, the caregivers felt well-being and were connected and comforted in difficult times in ways related to caring.

Stuckey (2001) used the Reconciled Life Perspective (RLP) to further clarify the connections among religion, spirituality, and significant life events by examining a group of Alzheimer's disease (AD) caregivers along with a matched comparison group of non-caregivers. This construct was selected by the researcher to help clarify the connection between religion, spirituality, and well-being (a condition under which spiritual and religious beliefs and practices have a positive impact on health outcomes). This model refers to the extent to which individuals have reconciled their spiritual and religious beliefs and practices with adverse events in their lives. Individuals with a strong RLP do not feel abandoned by a supreme being, but rather draw on this entity for support. They do not expect that they will be protected from traumatic life events because they adhere to a particular religion or spiritual practice or belief. This qualitative study proposed that strong religious and spiritual beliefs and practices are effective adaptation resources if an individual has a strong RLP. In this study, the researcher interviewed ten AD caregivers and ten non-caregivers about their life experiences and spiritual and religious beliefs. Five patterns were identified from the themes common to the participant's interview: attributes of God and faith; spiritual growth; values; definitions and details; and caregiving and other significant life events. Major differences in the

themes expressed by the two groups of participants did not emerge. Two themes were expressed more frequently by caregivers than by non-caregivers: "God has a plan and "prayer for coping and for comfort." However, the direct impact of a RLP on health and well-being was not examined in this study because the outcome data was not available. The investigator concluded that a RLP construct should be included in a study where those categorized as having a RLP are compared on quantifiable well-being outcome measures (e.g., physical health, depression, life satisfaction) to those without a RLP.

Leblanc, Driscoll, and Pearlin (2004) presented a stress process framework (Pearlin, 1999) as a model for understanding how religiosity may influence the expansion of caregiver stress. This model indicates that the process of social stress can be seen as combining three major conceptual domains, consisting of the sources of stress, the mediators of stress, and the manifestations of stress. The researchers used data from informal caregivers to a spouse with Alzheimer's disease or a related dementia to analyze the relationships among three variables: care-related stress, religiosity, and depression. The results indicated that religiosity appears to be largely unrelated to caregiver stress and stress expansion. The association between role overload and self-perceived religiosity might be indicative of a marshaling of coping resources emanating from an individual's personal religious beliefs and faith, yet the subsequent finding of a positive association between subjective religiosity and depression suggests that such coping does not ameliorate the harmful effects of stress. However, the researchers did not conclude that religiosity is immaterial to the caregiving experience, or to the deleterious effects of stress expansion.

Langa and colleagues (2001) presented a model of how the presence of diabetes may lead to increased levels of informal caregiving. They hypothesized that the majority of informal care for those with diabetes is provided to address disabilities in ADLs (walking, dressing, bathing, eating, transferring, and toileting), and IADLs (cooking, grocery shopping, using the telephone, taking medications, and managing money) that result directly from diabetes (e.g., mobility limitations due to neuropathy, muscle weakness, or impaired wound healing) or as mediated through increased rates of heart disease. The results indicated that diabetes imposes a substantial burden on elderly individuals, their families, and society, both through increased rates of disability and the significant time that informal caregivers must spend helping address associated functional limitations.

Williams, Dilworth-Anderson, and Goodwin (2003) used Allen and Britt's (1983) resource development theory to examine the relationship between multiple roles, specific combinations of these roles, available resources (economic, social, and personal) and caregiver role strain. This theory views economic, social, and personal resources as three conceptually distinct, but overlapping, resources that can minimize the negative consequences of stressful events. Economic resources such as education and income refer to resources that fulfill economic need. Social resources such as social support encompass primary and secondary relationships, and personal resources (health) are attributes of the individuals.

Williams and colleagues (2003) interviewed 148 African-American females who provided care to elderly family members. The objectives of their study were to

determine: (1) what is the relationship between the caregiver's other roles (marital, parental, employee), specific combinations of these roles, and role strain; and (2) what is the relationship between available resources (economic, social, and personal) and role strain? The results indicated that caregivers who lived with their care recipient had higher levels of strain. However, the fact that the higher levels of care recipient need (activities of daily living and cognitive impairment) was not associated with lower levels of role strain, and did not fully support their hypothesis that higher levels of physical and mental impairments of the care recipient displayed higher levels of role strain. The findings that caregivers with higher levels of education were more strained than caregivers with lower levels of education revealed that instead of being a resource, higher education was associated with higher levels of strain. Caregivers with higher levels of depressive symptomatology reported higher levels of strain. These caregivers were more stressed or strained when their own health (emotional) was poor as well as when the elder had poor physical health. Williams and colleagues stated that it would be a disservice to African-American caregivers to operate off the assumptions that they are a homogenous group that provides care with little emotional cost.

Pinquart and Sorensen (2005) stated that despite progress in the development of theoretical models on ethnic differences in caregiving, many available studies in that field are atheoretical and explorative and do not test theory-driven hypotheses. The researchers used a conceptual model that proposed that ethnic differences in personal resources and stressors (care recipient health and amount of care provided) exist, and that race or ethnicity is linked to differences in other caregiver background variables, such as gender,

family position, and income. They hypothesized that there were racial or ethnic differences in caregiving outcomes, which are due to existing baseline differences in physical and mental health as well as differences in stressors, resources, and background variables. Using meta-analysis to integrate the results of 116 empirical studies, the results indicated that ethnic minority caregivers were from a lower socioeconomic group, were younger, were less likely to be married, and were more likely to receive informal support. These caregivers also provided more care than White caregivers and possessed stronger beliefs about filial obligations than White caregivers. Asian-American caregivers, but not African-American and Hispanic caregivers used less formal support than non-Hispanic White caregivers. African-American caregivers displayed lower levels of caregiver burden and depression than White caregivers; however, Hispanic and Asian-American caregivers were more depressed than their White non-Hispanic peers. All groups of ethnic minority caregivers reported worse physical health than Whites caregivers. The researchers concluded that these results suggested that more specific theories are needed to explain the differential effects of caregiving among minority groups.

In summary, the various theories discussed in this chapter have their strengths and weaknesses. They support a multitude of beliefs concerning, religious/spiritual coping, stress, and caregiver's health. Although most of these theories represented in this chapter confirmed the need to pursue research that examines the role of religious/spiritual coping among informal caregivers in general, Folkman and Lazarus' Stress Process Model (1984) was used to review the relationship between stressors and religious/spiritual

coping among African-American caregivers of older adults. Caregiver's stress, religion/spirituality, and health appear to be variables that fit well within this model. First, a caregiver's religious/spiritual beliefs, activities, and practices can form an important part of the foundation and context of caregiving. Second, the study of these variables supports the body of literature that reports increased stress motivates the engagement of religious coping (Folkman, Chesney, Cooke, Broccellarie, & Collette, 1994; Kaye & Robinson, 1994; Salts, Denham, & Smith, 1991; Wheaton, 1985). Finally, religious/spiritual coping can be viewed as a mediator of stress, in the caregiver's ability to use religiosity/spirituality as an internal coping mechanism that promotes less perceived stress and good overall health (Figure 1).

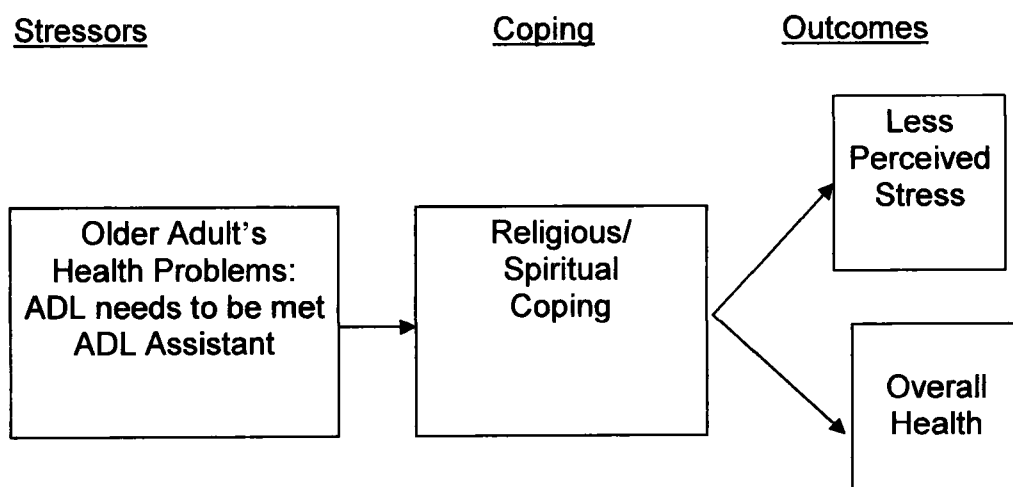


Figure 1. Religious/Spiritual Coping, Stress, and Overall Health

CHAPTER III

METHODOLOGY

The purpose of this study was to examine the role of religious/spiritual coping among African-American informal caregivers of older adults. The dependent variable (religious/spiritual coping) was examined in relationship to overall health and perceived stress (independent variables) among co-residing African-American informal caregivers of community dwelling older adults. The methods and procedures used are divided into five key components: the research design, description of the site; sample and population; instrumentation; treatment of data, and limitations of the study.

Research Design

A cross-sectional approach was used in this descriptive and explanatory study. The study was designed to assess data in order to analyze the relationship between religious/spiritual coping, overall health, and perceived stress among co-residing African-American informal caregivers of community dwelling older adults.

This descriptive and explanatory research design included the descriptive analysis of the demographic characteristics of the respondents. In addition, this research design facilitated the explanation of the statistical relationship between religious/spiritual coping, overall health, and perceived stress experienced by co-residing African-American informal caregivers of physically and/or emotionally dependent community dwelling older adults.

Description of the Site

Quantitative data used in these analyses was provided by participants selected from the first wave of the longitudinal Family Relationships in Late Life Two (FRILL2) Study; this was a primary analysis from secondary data collected by the FRILL2 Study. The Family Relationship in Late Life (FRILL, R01AG15321) project is funded by the National Institute of Health/National Institute on Aging. Under the direction of Dr. Gail Williamson at the University of Georgia, FRILL focuses on the complex factors that influence how providing care for an older relative affects the physical and emotional well-being of both caregivers and care recipients.

The first FRILL project (1997-2002) was collaboration among researchers at the University of Georgia, the University of Pittsburgh, and the University of Texas- Southwestern Medical Center at Dallas. The study involved multiple interviews with family members who provided care to elderly relatives and their care recipients. FRILL1 examined a wide range of issues, including physical and mental health, cognitive function, interpersonal relationships, and quality of care. Interviews were conducted by professional researchers in participants' homes to produce non-threatening (and, often, beneficial) conditions in which participants can comfortably discuss their experiences.

Building on the infrastructure and extending the accomplishments of FRILL1, FRILL2 (2002 – 2007) is currently enrolling 500 co-residing caregiver-care recipient dyads for 3 longitudinal assessments at 18-month intervals. An entirely new component will follow caregivers who transition out of caregiving (e.g., through care recipient death or institutionalization) at 6-month intervals. The FRILL2 project is collaboration among

researchers at the University of Georgia, the University of Pittsburgh, and the University of Alabama at Tuscaloosa.

Sample and Population

The analyses presented in this paper are based on the first wave of interviews from the Family Relationships in Late Life (FRILL2) Project. The voluntary sample was recruited from Athens, Georgia; Pittsburgh, Pennsylvania; Tuscaloosa, Alabama; and surrounding areas. To be eligible for the study, co-residing caregivers had to be primarily responsible for the care of a cognitively or physically impaired care recipient over the age of 60 and had to provide unpaid help for at least one basic activity of daily living or two instrumental activities of daily living.

A primary goal of FRILL2 was to over sample African-American caregiving dyads in order to obtain data sufficient to address issues (e.g., longitudinal comparisons between White and African-American caregivers) conspicuously missing in previous research on the quality of informal elder care. Within these constraints, the researchers attempted to obtain as representative a sample as possible, employing the services of the Survey Research Center at the University of Georgia. These efforts began with Random Digit Dialing (RDD) in the areas including and surrounding the data collection sites. The researchers then narrowed their search to Age-Targeted RDD (e.g., individuals 60 years of age and older, according to U.S. Census data). These methods produced more eligible White than African-American dyads. To increase the number of African-American participants, they used community-based snowball referral methods at the Georgia site in which completed African-American dyads were re-contacted and asked to provide the names and telephone numbers of other potentially eligible dyads. Project staff then

contacted these individuals. RDD methods identified, in initial screening, 877 potential dyads. Of these, 35% refused to be interviewed, 5.6% could not be reached due to technical phone problems, and 18% were subsequently determined to be ineligible based on study criteria. Snowballing methods produced 95 potential dyads, of which 14.7% refused participation. Together, these methods resulted in a sample that was 55% White and 45% African-American.

In sum, recruitment efforts resulted in 765 eligible dyads, 321 (42%) of which declined participation, resulting in a sample of 444 caregivers. Of these, 27 caregivers had enough missing data to be excluded from these analyses, resulting in 417 caregivers. Analyses reported in this study included 173 African-American caregivers from total number of respondents ($N = 417$). The majority of the participants resided in the South (73 %); 58 % were from the Athens GA area, 27 % were from the Pittsburgh, Pennsylvania area; and 15 % were from the Tuscaloosa, Alhambra area.

Face-to-face structured interviews lasting between 1.5 and 2 hours, for which participants were paid \$25, were conducted in respondents' homes by pairs of carefully trained interviewers. To prevent data contamination, caregivers and care recipients were interviewed separately and simultaneously.

The FRILL2 study was approved by the Institutional Review Boards (IRB) of the Universities of Alabama, Georgia, and Pittsburgh. This present study (The Role of Religious/Spiritual Coping among African-American Informal Caregivers of Older Adults) was approved by Clark Atlanta University's Institutional Review Board.

Instrumentation

Religious/spiritual coping was assessed using the Brief Religious/Spiritual Coping (RCOPE) Short Form (R/SC). The 3-item that load highest on the positive (+R/SC) and negative (-R/SC) religious/spiritual coping factors, respectively (Pargament, Smith, Koenig, and Perez, 1998). These two subscales of the Brief RCOPE allow for examination of both the potentially positive and negative effects of religiosity/spirituality (See Appendix A). The items can be rated in terms of how the individual copes with a particular stressor, or with life stressors in general. The items also have a theoretical base and suggest how religion/spirituality may affect health (Fetzer, 1999). According to Pargament (1997), several studies (Bearon & Koenig, 1990; Bjorck & Cohen, 1993; Lindenthal, et al., 1970; Pargament, Smith, Koenig, & Perez; Pargament, 1990; and Pargament, 1993), have shown that measures of specific methods of religious/spiritual coping continue to predict outcomes to life stressors significantly. The results of these studies suggest a model in which religious/spiritual coping methods mediate the relationship between global variables (i.e., frequency of prayer, denomination, and frequency of church attendance) and outcomes of stressful life events. In sum, in times of crisis people translate their general religious orientation into specific methods of religious/spiritual coping (Fetzer, 1999).

This study also employed Pargament, Smith, Koenig, and Perez' (1990) Overall Religious/Spiritual Coping Item (Overall R/SC). This single item taps into the overall degree of religious/spiritual involvement in coping (See Appendix A): "To what extent is your religion involved in understanding or dealing with stressful situations in any?"

The Perceived Stress Scale (PSS) measure was used to assess caregivers' general perceived stress. This 14 item scale was designed to assess the degree to which respondents found their lives unpredictable, uncontrollable, and overloading. PSS is used as an outcome measure of experienced levels of stress (Cohen, Kamarck, & Mermelstein, 1983). Participants were asked about feelings and thoughts within the last thirty days prior to taking the survey (See Appendix A).

One measure was used to assess caregiver's overall health (See Appendix A). This tool is a one-item measure: "How would you rate your overall health right now?" (1 = poor, 5 = excellent).

Treatment of the Data

This study utilized a cross-sectional approach to examine the relationship of sociodemographic background, religious/spiritual coping, overall health, and perceived stress among a sample of African-American informal caregivers of physically and emotionally dependent community-dwelling older adults. A quantitative approach was used from data collected from face-face interviews conducted with caregivers who reside with the care recipient. A frequency distribution of independent variables was used to develop a demographic profile of participants in the study.

Two test statistics was employed. First, Chi Square was used to test whether there was a statistical significance at the .05 level of probability among the variables in the study. Second, Pearson's correlation coefficient r was used to measure the strength of the relationship among variables of interest and demographic factors. According to Shannon & Davenport (2001), Pearson coefficients range from -1.0 to +1.00. A correlation coefficient of -1.0 indicates a perfect negative correlation, while a +1.0

describes a perfect positive relationship. The closer the correlation coefficient is either -1.0 or +1.0, the stronger the relationship. Finally, the data were analyzed using the SPSS system.

Limitations of the Study

There were several limitations of this study. First, limitations exist with measures used to assess religious/spiritual coping and stress among informal caregivers because the measures are not specific to the use of religious/spiritual as a coping mechanism among informal caregivers. Second, this study was limited to a small sample of African-American informal caregivers and does not represent the total population of African-American informal caregivers. Thus, this limits the ability to generalize the study. Third, a vast majority of the participants of this study resided in the South (Georgia and Alabama). However, there was no information available as to the length of residency of the respondents; therefore, the researcher was unable to explore the influence religious/spiritual coping may have on African American informal caregivers with lifetime Southern residency compared to those who may have migrated back to the South.

CHAPTER IV

PRESENTATION OF FINDINGS

As previously stated, the primary purpose of this study was to examine the relationship of socio-demographic background, religious/spiritual coping, overall health, and perceived stress among co-residing African-American informal caregivers of physically and/or emotionally dependent community dwelling older adults. This chapter presented the findings as well as the statistical tests used to determine the significance of the variables addressed in the hypotheses. The findings were categorized into two sections: demographic data and research questions and hypotheses.

Demographic Data

This section provides a profile of the study participants. Descriptive statistics were used to analyze the following: gender, care giver's age group, care recipient's age, marital status, education, caregiver's religious preference, relationship to care recipient, employment status, annual household income, whether income is adequate, how long caregiver has been providing care, and whether care recipient has been diagnosed with Alzheimer's or dementia.

Participants' data for this study was composed of informal caregivers ($N = 417$) from the first wave of the Family Relationships in Late Life Two (FRILL 2) project, a prospective study of family caregiver-care recipient dyads recruited from communities served by the University of Georgia, the University of Pittsburgh, and the University of

Alabama-Tuscaloosa. A voluntary sample was recruited via a probability based random digit dialing. Data was collected using structured face-to-face interviews with caregivers who co-reside with care recipients (older adults). Caregivers were interviewed separately from the older adults. For the purpose of this study, a final sample size included 173 African-American participants selected from the first wave of the FRILL 2 Study.

Table 1: *Demographic Profile of Study Participants*

Variable	Frequency	Percent
Gender		
Female	122	70.0
Male	51	30.0
Caregiver Age (CG) Group		
18-29	13	7.7
30-39	14	8.2
40-49	26	15.1
50-59	53	30.6
60-69	37	21.5
70 and over	30	17.5
Care Recipient (CR) Age Group (Older Adult)		
Under age 65	23	13.3
65-74	59	34.2
75-84	49	28.3

Table 1: *Demographic Profile of Study Participants* continued

Variable	Frequency	Percent
Care Recipient (CR) Age Group (Older Adult) continued		
85 and over	42	24.5
Marital Status		
Single	47	27.2
Married	89	51.5
Separated	9	5.2
Divorced	17	9.8
Widowed	11	6.4
Education		
Some High School	51	29.5
High School Graduate	55	31.8
Some College	42	24.3
College Graduate	12	6.9
Graduate Degree	13	7.5
Caregiver's Religious Preference		
Baptist	117	67.6
Methodist	16	9.2
Other	34	19.7
None	6	3.5

Table 1: *Demographic Profile of Study Participants* continued

Variable	Frequency	Percent
Relationship To CR		
Spouse	62	35.8
Child	74	42.8
Grandchild	16	9.2
Other Relative	17	9.9
Other (Non relative)	4	2.3
Employment Status		
Homemaker	9	5.2
Full Time	39	22.5
Part Time	16	9.2
Unemployed	28	16.1
Retired	50	28.9
Disabled	26	15.0
Other	5	2.9
Annual Household Income		
Less than \$5,000	18	10.4
\$5,000 to \$14,999	52	30.1
\$15,000 to \$29,999	41	23.7
\$30,000 to \$49,999	27	15.6

Table 1: *Demographic Profile of Study Participants* continued

Variable	Frequency	Percent
Annual Household Income continued		
\$50,000 to \$69,999	10	5.8
\$70,000 and over	7	4.1
Did not know or unable to answer	15	8.7
Refused To Answer	3	1.7
Employment Status		
Homemaker	9	5.2
Full Time	39	22.5
Part Time	16	9.2
Unemployed	28	16.1
Retired	50	28.9
Disabled	26	15.0
Income Is Adequate		
More Than Adequate	5	2.9
Adequate	75	43.4
Somewhat Inadequate	62	35.8
Not At All Adequate	30	17.3
Refused to Answer	1	.6

Table 1: *Demographic Profile of Study Participants* continued

Variable	Frequency	Percent
How Long Caregiver Provided Care		
12 months or less	14	8.2
13 to 60 months	80	46.3
61 to 120 months	40	23.2
121 to 240 months	25	14.6
Over 240 months	12	7.2
Did not know	2	1.2
CR Diagnosed With Alzheimer's Or Dementia		
NO	129	74.6
YES	44	25.4

As indicated in Table 1, the typical participant in this study was an African-American female who was married, a high school graduate, had an annual household income less than \$15,000, and who had provided thirteen to sixty months of care to an older adult. However, it is important to note that thirty percent of the caregivers in this study were male. Research concerning caregiving in the general population suggests that approximately one out three caregivers is male (MetLife, 2003). The majority of the caregivers (70%) were fifty years of age or older. Most of the participants were retired

(30%); however, thirty nine (23%) were employed full time. Forty-three percent of the respondents indicated that the household income was adequate to meet their needs. Most caregivers (68%) reported Baptist as their religious preference.

In regards to their relationship to care recipient, 43 % of the participants provided care to parents and 36% provided care to their spouse. The majority of the care recipients were 65 years of age and older, 34 % were in the "young- old" age group (65-74), 28 % were in the "old-old" age group (75-84), and 25% were in the "oldest old" age group (85 and over). One hundred-twenty nine (75%) of the care recipients have not been diagnosed with Alzheimer's or dementia. However, forty-four (25%) caregivers reported caring for an older adult diagnosed with Alzheimer's or dementia. As indicated in Table 2, the majority of the participants resided in the South (73 %); 58 % were from the Athens, GA area; 27 % were from the Pittsburg, Pennsylvania area; and 15 % were from the Tuscaloosa, Alabama area.

Table 2: *Data Collection Site*

	Frequency	Percent
Georgia	100	57.8
Pennsylvania	47	27.2
Alabama	26	15.0
Total	173	100.0

It is important to clarify if the three sites in the study were identified as urban or rural. According to the U. S. Census Bureau (2007), urban is defined as all territory, population and housing units in urban areas, which include urbanized areas and urban clusters. An area is generally classified as urban when there is a large central place and adjacent densely settled census blocks that together have a total population of at least 2,500 for urban clusters, or at least 50,000 for urbanized areas. Urban classification cuts across other hierarchies and can be in metropolitan or non-metropolitan areas. In contrast, rural is defined as territory, population, and housing units not classified as urban. Rural classification cuts across other hierarchies and can be in metropolitan or non-metropolitan areas. In sum, The U. S. Census Bureau does not identify or classify entire counties as urban or rural. Geographic areas such as places, counties, metropolitan areas, etc, are often split between urban and rural territory, and the housing units they contain are classified as part urban and part rural.

In reference to the three sites included in this study, the areas were mainly classified as urban (See Table 3). At this time, the researcher is unable to identify which participants resided in a rural or urban area of their county. For example, Barrow County, population 46, 144, is located less than twenty five miles from the Georgia site; however, 24,489 of the residents reside in a rural area while 21, 655 of the residents live inside an urban setting (U. S. Census, 2007).

Table 3: *Urban and Rural Site Population Profile*

	Clark County, GA (Athens)	Allegheny County, PA (Pittsburg)	Tuscaloosa County, AL (Tuscaloosa)
Total	101,489	1,281,666	164,875
Urban	92,644	1,247,095	116,888
Rural	8,845	34,571	47,987

Activities of Daily Living Assistance

According to the Administration on Aging (2006), more than 22.4 million informal caregivers (unpaid) assist older adults who have at least one limitation with their activities of daily living. Such activities include bathing or showering, dressing, eating, getting in and out of bed, using the toilet, providing transportation, taking medications, doing laundry, preparing meals, shopping, managing money, using the telephone, doing heavy work, and/or doing light work. Henceforth, the type and extent of family care is largely determined by the older adult's functional status, intensity of needed care, and co-residence (Hooyman & Kiyak, 2005).

Therefore, results of the study displayed the kind of help care recipients needed from caregivers. The participants answered yes or no to whether the older adult (care recipient) needed any kind of help during the past week. "Help was defined as supervision, direction, or personal assistance (See Appendix A).

Table 4 represents the frequency distribution of 173 care recipients who needed help with bathing and showing, dressing, eating, getting in and out of bed, using the

toilet, providing transportation, taking medications, doing laundry, preparing meals, shopping, managing money, using the telephone, doing heavy work, and/or doing light work. Care recipients needed more help doing heavy work (68%), laundry (67%), and preparing meals (64%) than any other daily activities. The older adults (care recipients) of this study also needed more assistance with shopping (60%), doing light work (57%), transportation (55%), bathing and showering (47%), managing money (47%), dressing (43%), and taking care of personal business (43%) than their other daily activities.

Table 4: *Activities of Daily Living (ADL) Assistance Profile of Study Participants*

Variable	Yes		No		Total	
	#	%	#	%	#	%
Bathing and Showering	82	47	91	52.6	173	100.0
Dressing	74	43	99	57.2	173	100.0
Eating	18	10	155	89.6	173	100.0
Getting In-Out Of Bed	48	28	125	73.3	173	100.0
Using The Toilet	41	24	132	76.3	173	100.0
Transportation	95	55	78	45.1	173	100.0
Taking Medications	67	39	106	61.3	173	100.0
Laundry	116	67	57	32.9	173	100.0
Preparing Meals	110	64	63	36.4	173	100.0
Shopping	104	60	69	39.9	173	100.0
Managing Money	82	47	91	52.6	173	100.0
Personal Business	74	43	99	57.2	173	100.0
Using The Telephone	43	25	130	75.1	173	100.0
Doing Heavy Work	117	68	56	32.4	173	100.0
Doing Light Work	98	57	74	43.0	173	100.0

Research Questions and Hypotheses

There were six research questions and six null hypotheses in the study. This section provides an analysis of the research questions and a testing of the null hypotheses.

Caregiver Gender and Religion

Research Question 1: Is there a relationship between the utilization of religious/spiritual coping and gender among African-American informal caregivers of physically and emotionally dependent community dwelling older adults?

Hypothesis 1: There is no statistically significant relationship between the utilization of religious/spiritual coping and gender among African-American informal caregivers of physically and emotionally dependent community dwelling older adults.

Table 5 is a crosstabulation of religion helped to resolve stress by the sex of 170 caregivers. It shows the relationship between how religion help to resolve stress for caregivers and the sex of informal caregivers of older adults and indicates whether there was a statistically significance relationship between the two variables.

Table 5: *Crosstabulation Of Religion's Involvement In Resolving Stress By Sex Of Informal Caregivers (N=170)*

		<u>Religion Help Resolve Stress</u>									
		Not Involved At All		Not Very Involved		Somewhat Involved		Very Involved		Total	
		#	%	#	%	#	%	#	%	#	%
<u>Caregivers Sex</u>											
Female		4	2.4	8	4.7	18	10.6	90	52.8	120	70.6
Male		8	4.7	3	1.8	8	4.7	31	18.2	50	29.4
Total		12	7.1	11	6.5	26	15.3	121	71.2	170	100.0
Chi Square = .031 df 3											

Table 5 indicates that of the 170 caregivers, 147 (86.5 %) reported that the involvement of religion help resolve stress. Somewhat involved and very involved were combined to indicate involvement of religion to help resolve stress. The majority of female caregivers (63.4%) indicated that involvement with religion help resolve stress. When the chi square test was applied, the null hypothesis was rejected indicating that there was a statistically significant relationship (.031) between religious/spiritual coping and gender among African-American informal caregivers of physically and emotionally dependent community dwelling older adults at the .05 level of probability.

Caregiver Income and Religion

Research Question 2: Is there a relationship between the utilization of religious/spiritual coping and income among African-American informal caregivers of physically and emotionally dependent community dwelling older adults?

Hypothesis 2: There is no statistically significant relationship between the utilization of religious/spiritual coping and income among African-American informal caregivers of physically and emotionally dependent community dwelling older adults. Table 6 is a crosstabulation of religion help to resolve stress by the annual household income of 154 care givers. It shows the relationship between how religion help to resolve stress for caregivers and the annual income of informal caregivers of older adults and indicates whether there was a statistically significance relationship between the two variables.

Table 6: *Crosstabulation Of Religion's Involvement In Resolving Stress By The Income Of Care Givers (N=154)*

	<u>Religion Help Resolve Stress</u>									
	Not Involved At All		Not Very Involved		Somewhat Involved		Very Involved		Total	
	#	%	#	%	#	%	#	%	#	%
<u>Annual Income</u>										
Under \$5,000	1	0.6	4	2.6	1	0.6	12	7.8	18	11.7
\$5,000-4,999	8	4.7	3	1.8	8	4.7	31	18.2	50	29.4

Table 6: *Crosstabulation Of Religion's Involvement In Resolving Stress By The Income Of Care Givers (N=154) continued*

<u>Religion Help Resolve Stress</u>										
	Not Involved At All		Not Very Involved		Somewhat Involved		Very Involved		Total	
	#	%	#	%	#	%	#	%	#	%
<u>Annual Income</u>										
\$5,000-14,999	0	0.0	2	1.3	4	2.6	21	13.6	27	17.5
\$15,000-29,999	3	1.9	0	0.0	2	1.3	17	11.0	22	14.3
\$30,000-39,999	0	0.0	0	0.0	4	2.6	13	8.4	17	11.0
\$40,000-59,999	0	0.0	0	0.0	1	0.6	9	5.8	10	6.5
\$60,000-79,999	0	0.0	0	0.0	3	1.9	1	0.6	4	2.6
\$80,000-99,999	1	0.6	0	0.0	2	1.3	3	1.9	6	3.9
\$100,000 up	0	0.0	0	0.0	1	0.6	0	0.0	1	0.6
Totals	11	7.1	8	5.2	23	14.9	112	72.7	154	100.0
Chi Square = .001 df 30										

Table 6 indicates that of the 154 caregivers, 145 reported that involvement with religion help resolve stress. Somewhat involved and very involved were combined to indicate involvement of religion to help resolve stress. The largest number of caregivers

(16.2%) reported annual income of \$5,000 to \$14,999 indicated that involvement with religion help resolve stress. The second largest number of caregivers (12.3%) reported annual income of 15,000-29,999 also indicated that involvement with religion help resolve stress. When the chi square test was applied, the null hypothesis was rejected indicating that there was a statistically significant relationship (.001) between religious/spiritual coping and annual income among African-American informal caregivers of physically and emotionally dependent community dwelling older adults at the .05 level of probability.

Caregiver Education and Religion

Research Question 3: Is there a relationship between the utilization of religious/spiritual coping and education among African-American informal caregivers of physically and emotionally dependent community dwelling older adults?

Hypothesis 3: There is no statistically significant relationship between the utilization of religious/spiritual coping and income among African-American informal caregivers of physically and emotionally dependent community dwelling older adults.

Table 7 is a crosstabulation of religion help to resolve stress by the educational level of 170 care givers . It shows the relationship between how religion helps to resolve stress for caregivers when educational level is the major consideration for informal caregivers of older adults and indicates whether there was a statistically significance relationship between the two variables.

Table 7: Crosstabulation Of Religion's Involvement In Resolving Stress By Education Of The Caregivers (N=70)

<u>Religion Help Resolve Stress</u>										
	Not Involved At All		Not Very Involved		Somewhat Involved		Very Involved		Total	
	#	%	#	%	#	%	#	%	#	%
<u>Education Level</u>										
Under 7 years	0	0.0	0	0.0	1	0.6	4	2.4	5	2.9
Junior High	2	1.2	0	0.0	2	1.2	8	4.7	12	7.1
Some HiSchool	3	1.8	4	2.4	3	1.8	23	13.5	33	19.4
HiSchool Grad	3	1.8	5	2.9	8	4.7	37	21.8	53	31.2
Trade School	1	0.6	0	0.0	3	1.8	14	8.2	18	10.6
Some College	1	0.6	0	0.0	3	1.8	20	11.8	24	14.1
College Grad	0	0.0	2	1.2	2	1.2	8	4.7	12	7.1
Graduate Degree	2	1.2	0	0.0	4	2.4	7	4.1	13	7.6
Total	12	7.1	11	6.5	26	15.3	121	71.2	170	100.0
Chi Square = .644 df 21										

Table 7 indicates that of the 170 caregivers, 147 reported that involvement with religion help resolve stress. Somewhat involved and very involved were combined to indicate involvement of religion to help resolve stress. The largest number of caregivers (26.5%) reported high school graduate educational level indicated that involvement with

religion help resolve stress. The second largest number of caregivers (15.3%) reported some high school educational level also indicated that involvement with religion help resolve stress. When the chi square test was applied, the null hypothesis was accepted indicating that there was no statistically significant relationship (.644) between religious/spiritual coping and educational level among African-American informal caregivers of physically and emotionally dependent community dwelling older adults at the .05 level of probability.

Caregiver Residency and Religion

Research Question 4: Is there a relationship between the utilization of religious/spiritual coping and education among African-American informal caregivers of physically and emotionally dependent community dwelling older adults?

Hypothesis 4: There is no statistically significant relationship between the utilization of religious/spiritual coping and income among African-American informal caregivers of physically and emotionally dependent community dwelling older adults.

Table 8 is a crosstabulation of religion help to resolve stress by the data collection sites of 170 caregivers. It shows the relationship between how religion help to resolve stress for caregivers and the location of informal caregivers of older adults and indicates whether there was a statistically significance relationship between the two variables.

Table 8: Crosstabulation Of Religion's Involvement In Resolving Stress By The Location Of Caregivers (N=170)

	<u>Religion Help Resolve Stress</u>									
	Not Involved At All		Not Very Involved		Somewhat Involved		Very Involved		Total	
	#	%	#	%	#	%	#	%	#	%
<u>Collection Sites</u>										
Georgia	7	4.1	8	4.7	10	5.9	72	42.4	97	57.1
Pennsylvania	3	1.8	2	1.2	11	6.5	31	18.2	47	27.6
Alabama	2	1.2	1	0.6	5	2.9	18	10.6	26	15.3
Total	12	7.1	11	6.5	26	15.3	121	71.2	170	100.0
Chi square = .501 df 6										

Table 8 indicates that of the 170 caregivers, 147 reported that involvement with religion help resolve stress. Somewhat involved and very involved were combined to indicate involvement of religion to help resolve stress. The largest number of caregivers (48.3%) resided in Georgia indicated that involvement with religion help resolve stress. The second largest number of caregivers resided in Pennsylvania (24.7%) also indicated that involvement with religion help resolve stress. When the chi square test was applied, the null hypothesis was accepted indicating that there was no statistically significant relationship (.501) between religious/spiritual coping and residency of African-American

informal caregivers of physically and emotionally dependent community dwelling older adults at the .05 level of probability.

Caregiver Overall Health and Religion

Research Question 5: Is there a relationship between the utilization of religious/spiritual coping and overall health among African-American informal caregivers of physically and emotionally dependent community dwelling older adults?

Hypothesis 5: There is no statistically significant relationship between the utilization of religious/spiritual coping and overall health among African-American informal caregivers of physically and emotionally dependent community dwelling older adults.

Table 9 is a crosstabulation of religion help to resolve stress by the overall health of 169 caregivers. It shows the relationship between how religion help to resolve stress and overall health for informal caregivers of older adults and indicates whether there was a statistically significance relationship between the two variables.

Table 9: Crosstabulation Of Religion's Involvement In Resolving Stress By Overall Health Care Givers (N=169)

	<u>Religion Help Resolve Stress</u>									
	Not Involved At All		Not Very Involved		Somewhat Involved		Very Involved		Total	
	#	%	#	%	#	%	#	%	#	%
<u>Overall Health</u>										
Poor	1	0.6	0	0.0	0	0.0	6	3.6	7	4.1

Table 9: *Crosstabulation Of Religion's Involvement In Resolving Stress By Overall Health Care Givers (N=169) continued*

	<u>Religion Help Resolve Stress</u>									
	Not Involved At All		Not Very Involved		Somewhat Involved		Very Involved		Total	
	#	%	#	%	#	%	#	%	#	%
Fair	1	0.6	4	2.4	11	6.5	11	6.5	39	23.1
Good	6	3.6	6	3.6	9	5.3	51	30.2	72	42.6
Very Good	2	1.2	1	0.6	6	3.6	16	9.5	25	14.8
Excellent	2	1.2	0	0.0	0	0.0	8	4.7	10	5.9
Total	12	7.1	11	6.5	26	15.4	120	71.0	169	100.0
Chi square = .411 df 12										

Table 9 indicates that of the 169 caregivers, 146 reported that involvement with religion help resolve stress. Somewhat involved and very involved were combined to indicate involvement of religion to help resolve stress. The largest number of caregivers (35.5%) reported good overall health indicated that involvement with religion help resolve stress. The chi square test was applied, the null hypothesis was accepted indicating that there was no statistically significant relationship (.411) between religious/spiritual coping and overall health of African-American informal caregivers of physically and emotionally dependent community dwelling older adults at the .05 level of

probability. However, when good, very good, and excellent were combined, sixty-three percent of the participants reported good to excellent overall health.

Caregiver perceived stress and Religion

Research Question 6: Is there a relationship between the utilization of religious/spiritual coping and perceived stress among African-American informal caregivers of physically and emotionally dependent community dwelling older adults?

Hypothesis 6: There is no statistically significant relationship between the utilization of religious/spiritual coping and perceived stress among African-American informal caregivers of physically and emotionally dependent community dwelling older adults.

The bivariate analysis (Pearson's correlation coefficient), was used to examine the relationship between utilization of religious/spiritual coping and perceived stress.

Bivariate correlations are shown in Table 10. A significant correlation exists between religious/spiritual coping and perceived. A bivariate analysis was employed to examine separate relationship between the independent variable and dependent variable. Zero-order correlations displayed associations between religious/spiritual coping and perceived stress. . Higher use of religious/spiritual coping was associated with less perceived stress among African American informal caregivers of physically and emotionally dependent community dwelling older adults.

Table 10: *Bivariate Correlations Among Variables of Interest*
(*N* = 173)

Variable	1	2
1. Religious/Spiritual Coping	--	-.206**
2. Perceived Stress		--

* $p < .05$ ** $p < .01$

The test of this hypothesis, the bivariate analysis (Pearson's correlation coefficient), was used to look at the relationship between utilization of religious/spiritual coping and perceived stress. The bivariate analysis in Table 10 indicates that there was a statistically significance association between the utilization of religious/spiritual coping and perceived stress. There was a strong relationship between the utilization of religious/spiritual coping and perceived stress. Thus, the null hypothesis was rejected.

In conclusion, crosstabulation were used to assess the relationship between the utilization of religious/spiritual coping, gender, income, education, and residency among African-American informal caregivers of physically and emotionally dependent community dwelling older adults. The results indicated that there was a statistically significant relationship (.031) between religious/spiritual coping and gender among the caregivers. The relationships between these variables were noted to be stronger among female caregivers. There was also a statistically significant relationship (.001) between religious/spiritual coping and income. The relationships between these variables were

noted to be stronger among caregivers with annual income from \$5,000 to \$14,999. The results of this study also indicated that there was no statistically significant relationship between religious/spiritual coping, educational level (.644), and residency (.501).

A crosstabulation was employed to test the strength of the association between religious/spiritual coping and overall health. However, there was a weak relationship (Chi square = .501) between the two variables (See Table 9). Therefore, the null hypothesis was accepted. There was no statistically significant relationship between the utilization of religious/spiritual coping and overall health.

The majority of the participants of this study were married (52%) females (70%) providing care to co-residing older adults sixty five years of age or older (87%) who live in various communities. The majority of respondents (97%) reported a religious affiliation; however, most of the caregivers stated their religious preference was Baptist (68%). The results of the study indicated a strong relationship between the utilization of religious/spiritual coping and perceived stress. However, no relationship was found between the utilization of religious/spiritual coping and overall health. In sum, the findings suggest that African-American informal caregivers (co-residing with their elderly care recipients) who use religious/spiritual coping experience less stress.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

The purpose of this study was to assess the potential role of religious/spiritual coping as it relates to the experience of stress and overall health among African-American caregivers who co-reside with their care recipients. The research study was designed to examine the relationship between religious/spiritual coping, perceived stress, and overall health among African-American informal caregivers of physically and emotionally dependent community dwelling older adults. Shah, Snow, and Kunik (2001) investigated the prevalence of religiously based coping mechanisms used by Alzheimer's caregivers and found a high utilization of spiritual and religious coping mechanisms among these caregivers. The results of this study support research that yield a high utilization of religious/spiritual coping as a coping mechanism among caregivers.

The conclusions, implications, and recommendations of the research findings are discussed in this chapter. Recommendations are proposed for future discussions for policymakers, social workers, practitioners, administrators, gerontologists, spiritual leaders, and community workers.

An exploratory research design was selected to analyze the relationship between two independent variables (perceived stress and overall health) and the dependent variable (religious/spiritual coping). Participants of the study consisted of caregiver-recipient dyads from the FRILL 2 study that were recruited from communities served by the University of Georgia, the University of Pittsburgh, and the University of Alabama-

Tuscaloosa. The sample population included 173 African-American co-residing caregivers selected from the first wave of the FRILL 2 study. The statistical treatment of the data employed descriptive statistics, which included frequency distribution, percentages, crosstabulation, and bivariate analysis using Pearson's correlation coefficient.

A descriptive analysis of the demographic data revealed that 70% of the participants were African-American female caregivers between the ages of 50-59 (30.6%). The results support the research literature that a majority of caregivers are women, mostly wives and adult daughters (Family Caregiver Alliance, 2006). Additionally, thirty percent of the caregivers in this study were male; this supports the literature that approximately one out of three caregivers is male (MetLife, 2003). The literature indicates that African-American caregivers are more likely to be single, never married, and employed compared to Caucasian or Hispanic caregivers (NAC & AARP, 2004); however, fifty-two percent of the population surveyed in this study reported married as their marital status, and the largest number of participants (33.7%) was employed.

According to Hooyman & Kiyak (2005), informal caregivers of older adults (65+) are primarily adult children (42%), followed by partners or spouses (25%). The majority of the caregivers in this study provided care to a parent (43%) or spouse (36%). Eighty-seven percent of the care recipients were 65 years of age and over.

Religion in the lives of African-Americans is multifaceted, complex, and diverse. Their faith has many avenues of expression, for example, church services, public and

private behaviors, attitudes, and beliefs. Black religious tradition and the Black Church have remained resilient and grounded in the lives of individuals, families, and communities (Taylor, Chatters, & Levin, 2001). The findings in this research support studies that identify religious involvement as an important facet within the African-American family. The majority of the participants (97%) reported a religious preference.

Researchers continue to study caregiver's health because it is important to society. As the aging population continues to increase, more family members will provide care for their loved ones. Henceforth, it is important to study health risks associated with caregiving and explore successful interventions.

Interventions, such as religious/spiritual coping, can be used to relieve psychological distress, as well as the stresses of caregiving (Moberg, 2005). This study supports research that examines how religion and spirituality influence mental health (Armstrong & Crwother, 2002; Chatters, 2000; Koenig, 1997). Religious/spiritual coping was examined as a coping mechanism used during caregiving. The assumption was based on various studies that reported that increased stress motivated the engagement of religious coping (Folkman, Chesney, Cooke, Broccellarie & Collette, 1994; Kaye & Robinson, 1994; Salts, Denham, & Smith, 1991; Wheaton, 1985). The results of this study support the evidence that there is a strong relationship between religious/spiritual coping and perceived stress. It was also hypothesized that caregivers who use religious/spiritual coping will experience less perceived stress. Results of this study suggest that the greater use of religious/spiritual coping is associated with less perceived

stress among African-American informal caregivers of physically and emotionally dependent community dwelling older adults.

Research studies suggest that religiosity (religion) and spirituality have a positive effect on health (Koenig, 1997; Chatters, 2000; & Moberg, 2005). The findings from this study do not support this literature. In this study, it was hypothesized that African American caregivers who use religious/spiritual coping mechanisms have good overall health. However, the results of this study suggest that the greater use of religious/spiritual coping is not associated with overall health among African-American informal caregivers of physically and emotionally dependent community dwelling older adults.

Strong kinship bonds within the African- American family can be traced back to African heritage and culture (Hill, 1971; Royse & Turner, 1980; and Billingsley, 1994). However the face of the Black family has changed overtime. In 1979/80 black women were prominent in the provider role and made great contributions to the economic viability of their families, and less than 10 percent of two-parent households were supported by earnings from the wife's employment. However, by the 1990's the two-parent African-American families begin to decrease as the multigenerational, extended, and blended families increased (Billingsley, 1994). According to Dilworth-Anderson and Rhoden (2000), African-American families continue to survive through the strength and support of mothers, extended family relationships, and women-centered child care arrangements. Although many women within the African-American family continue to economically contribute to the home, they also continued to be identified as primary caregivers within the family and African-American community in general. In sum, the

findings in this study support this literature. The majority of the participants (70%) in this study were female.

Implications

Those who advocate for change in policy, use both quantitative and qualitative research to analyze specific issues related to specific populations. When researchers explore the causes of social problems, for some, their perspectives may influence their work and interpretation of causes. These causes may be personal, psychological, economic, biological, or environmental. However, researchers with public health and social work perspectives often emphasize occupational, economic, familial, peer, and neighborhood factors (Jansson, 2003). Therefore, it is important for social work advocates and professionals to develop interventions and programs that will enhance the quality of life for all older adults.

The National Association of Social Workers (2003) encourages and promotes advocacy for older adults by stating that there must be a shift from current practice and custom in both professional and societal approaches regarding the aging population. This organization of social workers supports the following policy statements that promote the well-being of all older adults (NASW, 2003):

- Advancement of programs, services, and professional behavior that promote and recognize that aging is not a disease that can be cured and promote productive aging and intergenerational compatibility
- Promotion of optimal, physical, mental, emotional, social, spiritual and functional well-being of people as they mature
- Advocacy for the preservation and integrity of social security and expansion of income resources for retirees
- Expansion of public, private, and commercial systems of economic security for older Americans, with special attention to the needs of older women
- Promotion of wellness, prevention, early intervention, and outreach services

- Advocacy for a comprehensive and affordable health care system for all older adults who are unable to pay the cost of their healthcare
- Development of reimbursable programs of support for services to family caregivers especially in regard to respite services
- Elimination of senior biases, stereotypes, and policies that influence poverty
- Strengthening of government oversight and requirements regarding the protection of vulnerable, older persons in the home, in communities, and in institutions
- Expansion of policies and programs that recognize and address the transportation, housing, and services access needs of elderly people in urban and rural areas
- Promotion of a policy that encourages the concept of death with dignity (NASW, pp. 324-325).

The importance of spirituality as it relates to aging has been discussed four times at the White House Conferences on Aging. Advocates admonished faith congregations to reach out to members, to monitor institutions, and to offer services for older adults. Recommendations were made and government agencies were asked to reach out to religious partners and recognize the value of spirituality among the aging population (Stein, 2001).

As a result of this study, the utilization of religious/spiritual coping among caregivers can be identified as an effective social work intervention when working with older adults and their families. Spiritual care as a tool of social service delivery can be very beneficial when working with the elderly. Social work practice with older adults is enhanced when social workers become comfortable using spiritual and religious issues to help their clients (Watkins, 2001). "Even those clients who are not religious or who are opposed to religion, can benefit from spiritual care because it helps them deal with issues related to the meaning and purpose of their lives, connect with their inner resources, and find a sense of belonging or community (Watkins, 2001, p. 144).

Recommendations

Research supports the relationship between religiosity/spirituality and health. A study that yields positive association between the greater use religious/spiritual coping and less perceived stress among African-American informal caregivers will enhance the lives of physically and emotionally dependent older adults and their caregivers. Such research supports the value of incorporating religious/spiritual aspects in social work programs and interventions. It also encourages the need for future research that will support the implementation of policy that establishes social services that utilizes religious/spiritual based interventions. The results of this study are relevant to practitioners who work directly with African-American disabled elders and their informal caregivers. The findings support the use of psychological interventions that help caregivers use their religious belief system to cope with their caregiving experience. These findings may also help facilitate caregiver interventions that increase collaborations among social workers, religious leaders, and community organizations.

In conclusion, it is so important for social workers, health care professionals and investigators to thoroughly review and research prevention and intervention programs in order to help increase the quality of care for all patients, especially African-American elders, their families, and their caregivers. The amount of knowledge, perception of health information presented, and an individual's spiritual/religious belief will have an impact on his/her response to stressful life events. Therefore, future research should identify a particular group (e.g. male caregivers and/or rural African-American caregivers) of informal caregivers and assess their use of religious/spiritual coping and its

relationship to caregiving experiences. Research that include religious/coping among informal caregivers will have important implications for community services and policy development.

APPENDICES

APPENDIX A

CAREGIVER QUESTIONNAIRE – TIME 1

DEMOGRAPHIC/GENERAL BACKGROUND INFORMATION

I'd like to start by getting general background information about you.

1. How old are you? cgage 1 (years) ____ ____
2. What is your relationship to (care recipient)? kin 1 ____
(CG is CR's _____)
 1. spouse or equivalent
 2. child
 3. sibling
 4. in-law
 5. parent
 6. niece/nephew
 7. aunt/uncle
 8. grandchild
 9. other
3. How long have you been providing care long 1 (months) ____ ____ ____
for (care recipient)?
4. Has (care recipient) been diagnosed as having dement1 ____
any condition that causes memory problems,
such as Alzheimer's disease or dementia?
0. No 1. Yes
If yes, specify _____
5. How old is (care recipient)? cragel 1 (years) ____ ____
6. Gender of caregiver. 1. Female 2. Male sex1 ____
7. How do you describe your race? race1 ____
 1. American Indian or Alaska Native
 2. Asian
 3. Black or African American
 4. Native Hawaiian or Other Pacific Islander
 5. White
 6. Other

APPENDIX A: Survey Questionnaire Continued

8. Would you consider your ethnicity to be: ethnic1 _____
 1. Hispanic or Latino
 2. Not Hispanic or Latino
9. What is your marital status? mstat1 _____
 1. Single, never married 4. Separated
 2. Living as married 5. Divorced
 3. Married 6. Widowed
10. How many people aged 18 or younger live in child1 _____
 your household?
11. How long have you and (care recipient) resid1(months) _____
 live together?
12. How much education have you had? educ1 _____
 1. Less than 7 years 5. Trade/technical
 2. Jr. high (7-9 years) 6. Partial college
 3. Partial high school 7. College graduate
 4. High school graduate, 8. Graduate/professional
 GED, or equivalent
13. What is your employment status right now? empl1 _____
 1. Housewife/Homemaker 6. Semi-retired
 2. Full-time employment 7. Retired
 3. Part-time employment 8. Disabled
 4. Unemployed, not looking 9. Other
 5. Unemployed, but looking _____
14. If you don't mind, would you tell me your income1 _____
 annual household income before taxes?
 1. Less than \$5,000 8. \$50,000 to \$59,999
 2. \$5,000 to \$9,999 9. \$60,000 to \$69,999
 3. \$10,000 to \$14,999 10. \$70,000 to \$99,999
 4. \$15,000 to \$19,999 11. \$100,000 or more
 5. \$20,000 to \$29,999
 6. \$30,000 to \$39,999
 7. \$40,000 to \$49,999

APPENDIX A: Survey Questionnaire Continued

15. How adequate is your income to meet your needs? incadq1 _____
1. Much more than adequate
 2. More than adequate
 3. Adequate
 4. Somewhat inadequate
 5. Not at all adequate
16. What is your current religious preference? relig1 _____
- | | | |
|-----------------|-----------------------|-----------------------|
| 0. None | 6. Roman Catholic | 12. Shintoist |
| 1. Lutheran | 7. Orthodox Christian | 13. Hindu |
| 2. Methodist | 8. Jewish | 14. Jehovah's Witness |
| 3. Baptist | 9. Islamic | 15. Other |
| 4. Episcopal | 10. Buddhist | |
| 5. Presbyterian | 11. Confucian | |

APPENDIX A: Survey Questionnaire Continued

PERCEIVED STRESS SCALE (PSS)

The next questions ask about your feelings and thoughts during the **last month**. For each question, tell me how often you felt or thought in each way.

0. Never 1. Almost never 2. Sometimes 3. Fairly often 4. Very often

- | | | |
|--|------|-------|
| 1. In the last month, how often have you felt that you were unable to control the important things in your life? | pss1 | _____ |
| 2. In the last month, how often have you felt confident about your ability to handle your personal problems? | pss2 | _____ |
| 3. In the last month, how often have you felt that things were going your way? | pss3 | _____ |
| 4. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them | pss4 | _____ |

RELIGIOUS/SPIRITUAL COPING SHORT FORM (R/SC-SF)

For these questions, think about how you try to understand and deal with major problems in your life. To what extent is each involved in the way you cope?

1. Not at all 2. Somewhat 3. Quite a bit 4. A great deal

- | | | |
|---|------|-------|
| 1. I think about how my life is part of a larger spiritual force. | rel1 | _____ |
| 2. I work together with God as partners to get through hard times. | rel2 | _____ |
| 3. I look to God for strength, support, and guidance in time of crisis. | rel3 | _____ |
| 4. I feel that stressful situations are God's way of punishing me for my sins or lack of spirituality. | rel4 | _____ |
| 5. I wonder whether God has abandoned me. | rel5 | _____ |
| 6. I try to make sense of the situation and decide what to do without relying on God. | rel6 | _____ |
| 7. To what extent is your religion involved in understanding or dealing with stressful situations in any way? | rel7 | _____ |
-
- | | |
|------------------------|----------------------|
| 1. Not involved at all | 3. Somewhat involved |
| 2. Not very involved | 4. Very Involved |

APPENDIX A: Survey Questionnaire Continued

Overall Health

1. Poor 2. Fair 3. Good 4. Very good 5. Excellent

How would you rate your overall health right now?

cghlth1 _____

ADL CHECKLIST

Now I am going to ask you some questions about the specific kinds of problems (care recipient) might have been having this past week. For each area, I will ask you whether he/she has needed any kind of help. "Help" means supervision, direction, or personal assistance.

0. No

1. Yes

1. During the past week, has (care recipient) needed any kind of help with bathing or showering? adl101 _____
2. During the past week, has care recipient) needed any kind of help with dressing? adl102 _____
3. During the past week, has care recipient) needed any kind of help with eating? adl103 _____
4. During the past week, has care recipient) needed any kind of help with getting out of bed or chairs? adl104 _____
5. During the past week, has care recipient) needed any kind of help with using the toilet or getting to the bathroom on time? adl105 _____
6. During the past week, has care recipient) needed any kind of help with transportation to places outside walking distance? adl106 _____
7. During the past week, has care recipient) needed any kind of help with taking medicine? adl107 _____

APPENDIX A: Survey Questionnaire Continued

8. During the past week, has care recipient) needed any kind of help with laundry? adl108 _____
9. During the past week, has care recipient) needed any kind of help preparing meals? adl109 _____
10. During the past week, has care recipient) needed any kind of help with shopping for items people usually shop for themselves? adl110 _____
11. During the past week, has care recipient) needed any kind of help managing money (paying bills, balancing checkbook, etc)? adl111 _____
12. During the past week, has care recipient) needed any kind of help taking care of personal business (insurance claims, taxes, etc)? adl112 _____
13. During the past week, has care recipient) needed any kind of help using the telephone? adl113 _____
14. During the past week, has care recipient) needed any kind of help doing heavy work (scrubbing floors, mowing lawn, etc)? adl114 _____
15. During the past week, has care recipient) needed any kind of help doing light work (dishes, straightening, etc)? adl115 _____

APPENDIX B: Clark Atlanta University Investigative Review Board Consent

CLARK ATLANTA UNIVERSITY

Institutional Review Board

Office of Sponsored Programs

223 James P. Brawley Drive, S.W. * ATLANTA, GA 30314-4391 * (404) 880-8000
Formed in 1988 by consolidation of Atlanta University, 1865 and Clark College, 1869

February 8, 2007

Ms. Linda F. Samuel <LFSamuel@yahoo.com>

School of Social Work

Clark Atlanta University

Atlanta, GA 30314

RE: The Role of Religious/Spiritual Coping Among African American Informal Caregivers of Older Adults.

Principal Investigator: Linda F. Samuel

Human Subjects Code Number: HR2007-1-199-2

Dear Ms. Samuel:

The Human Subjects Committee of the Institutional Review Board (IRB) has reviewed your revised protocol and approved of it as expedited and exempt from full IRB review in accordance with 45 CFR 46.101b.2.

Protocol Approval Code is HR2007-1-199-2/A

This approval is valid for one year from the date of this notice. This permit will therefore expire on February 1, 2008. Thereafter, continued approval is contingent upon the annual submission of a renewal form to this office. Any reaction or problems resulting from this investigation should be reported immediately to the IRB, the Department Chairperson and any sponsoring agency.

If you have any questions, please contact Dr. Georgianna Bolden at the Office of Sponsored Programs (404) 880-6979 or Dr. Paul I. Musey, (404) 880-6829.

APPENDIX B: Clark Atlanta University Investigative Review Board Consent continued

Sincerely:

Paul I. Musey, Ph.D.

Chair IRB: Human Subjects Committee

cc. Dr. Margaret Count-Spriggs mspriggs@cau.edu

Office of Sponsored Programs, Dr. Georgianna Bolden gbolden@cau.edu

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